Schedule of Benefits

Employer:	**County of El Paso**
MSA:	866233
Effective Date:	January 1, 2018
Schedule:	1C
Booklet Base:	1

For: Aetna Choice POS II Consumer Driven Health Plan (CDHP)

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$3,500	$5,000
Family Deductible*	$7,000	$10,000

*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 Maximum Out of Pocket Limit:

- For **network** expenses: $3,500.
- For **out-of-network** expenses: $8,000.

Family Maximum Out of Pocket Limit:

- For **network** expenses: $7,000.
- For **out-of-network** expenses: $16,000.

Lifetime Maximum Benefit per person	Unlimited	Unlimited

Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The 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.	Not Covered
Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician** log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*	Not Covered
Covered Persons ages 22 and over	1 visit	Not Covered
Preventive Care Immunizations *Performed in a facility or **physician's** office*	100% per visit No **copay** or **deductible** applies.	Not Covered
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	100% per visit No **copay** or **deductible** applies.	No Coverage
Obesity Maximum Visits per 12 consecutive months *(This maximum applies only to Covered Persons ages 22 & older.)*	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)**]*	No coverage
Misuse of Alcohol and/or Drugs Maximum Visits per 12 consecutive months	5 visits *	No Coverage
Note:** **In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		

Use of Tobacco Products Maximum Visits per 12 consecutive months	8 visits *****	No Coverage

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

Well Woman Preventive Visits ***Office Visits***	100% per visit No Calendar Year **deductible** applies.	Not Covered

Well Woman Preventive Visits Maximum Visits per Calendar Year	1 visit	Not Covered

Routine Cancer Screening ***Outpatient***	100% per exam No Calendar 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. *For details, contact your* ***physician,*** *[log onto the* ***Aetna*** *website www.aetna.com,] or call the number on the back of your ID card.]*	Not Covered

Prenatal Care ***Office Visits***	100% per visit No **copay** or **deductible** applies.	65% per visit <u>after Calendar Year</u> **deductible**

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

Comprehensive Lactation Support and Counseling Services		
Lactation Counseling Services *Facility or Office Visits*	100% per visit. No **copay** or **deductible** applies.	Not Covered.
Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per 12 months	Not Covered

***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 Calendar Year **deductible** applies.	No Coverage
Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.		
Family Planning Services Female Contraceptive Counseling Services -Office Visits.	100% per visit. No **copay** or Calendar Year **deductible** applies.	Not Covered.
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	Not Applicable
*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.		
Family Planning - Other Voluntary Sterilization for Males		
Outpatient	100% per visit after Calendar Year **deductible.**	65% per visit after Calendar Year **deductible**
Family Planning - Female Voluntary Sterilization		
Inpatient	100% per visit No **copay** or Calendar Year **deductible** applies.	65% per visit after Calendar Year **deductible**
Outpatient	100% per visit No **copay** or Calendar Year **deductible** applies.	65% per visit after Calendar Year **deductible**
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Family Planning Services - Female Contraceptives ***Female Contraceptive Generic Prescription Drugs***	100% per prescription or refill No Calendar Year **deductible** applies.	65% per prescription or refill after Calendar Year **deductible**.
Female Contraceptive Devices((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.	100% per prescription or refill No Calendar Year **deductible** applies.	65% per prescription or refill after Calendar Year **deductible**.

*For details, contact your **physician,** [log onto the **Aetna** website www.aetna.com,] or call the number on the back of your ID card.]*		
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**	65% per visit after Calendar Year **deductible**
Alternatives to Physicians' Office Visit		
E-Visit Online or Telephonic Consultation by a PCP	100% per visit after Calendar Year **deductible**	Not Covered
Specialist Office Visits	100% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**
Alternative to Specialist Office Visit		
E-visits Online or Telemedicine Consultation by a Specialist	100% per visit after Calendar Year **deductible**	Not Covered
Physician Office Visits-Surgery	100% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**
Walk-In Clinic Visit (Non-Emergency)		
Preventive Care Services* Immunizations	100% per visit No **copay** or Calendar Year **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.	65% per visit after Calendar Year **deductible**
Individual Screening and Counseling Services for Tobacco Use	100% per visit No **copay** or Calendar Year **deductible** applies.	65% per visits after Calendar Year **deductible**
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services

Individual Screening and Counseling Services for Obesity	100% per visit No **copay** or Calendar Year **deductible** applies.	65% per visits after Calendar Year **deductible**
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services
All Other Services	100% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**

***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**.

Physician Services for Inpatient Facility and Hospital Visits	100% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**
Administration of Anesthesia	100% per procedure after Calendar Year **deductible**	65% per procedure after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Emergency Medical Services		
Hospital Emergency Facility and Physician	100% per visit after the Calendar Year **deductible**	Paid the same as the Network level of benefits. 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	100% after Calendar Year **deductible**	65% after Calendar Year **deductible**
Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	100% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**

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	100% per test after Calendar Year **deductible**	65% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	100% per procedure after Calendar Year **deductible**	65% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	100% per procedure after Calendar Year **deductible**	65% 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**	65% per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	100% per procedure after Calendar Year **deductible**	65% per procedure after Calendar Year **deductible**
Hospital Facility Expenses Room and Board (including maternity)	100% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**
Other than Room and Board	100% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	100% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	60 days	60 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care (Outpatient)	100% per visit after the Calendar Year **deductible**	65% per visit after the Calendar Year **deductible**
Private Duty Nursing (Outpatient)	100% per visit after the Calendar Year **deductible**	65% per visit after the Calendar Year **deductible**
Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	100% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**
Hospice Care - Other Expenses during a stay	100% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days
Hospice Outpatient Visits	100% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	100% after Calendar Year **deductible**	65% after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders		
MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	100% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**
Other than Room and Board	100% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**

Inpatient Residential Treatment Facility Expenses	100% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	100% after Calendar Year **deductible**	65% after Calendar Year **deductible**

Outpatient Treatment Of Mental Disorders		
Outpatient Services	100% per visit after the Calendar Year **deductible**	65% per visit after the Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	100% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**
Other than Room and Board	100% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	100% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	100% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**
Outpatient Treatment of Substance Abuse		
Outpatient Treatment	100% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK (IOE Facility)**	**NETWORK (Non-IOE Facility)**	**OUT-OF-NETWORK**
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses	100 % after Calendar Year **deductible**	100% after Calendar Year **deductible**	65% after Calendar Year **deductible**
Transplant Physician Services (including office visits)	100% after Calendar Year **deductible**	100% after Calendar Year **deductible**	100% after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Ground, Air or Water Ambulance	100% after Calendar Year **deductible**	65% after Calendar Year **deductible**
Diabetic Equipment, Supplies and Education	100% after Calendar Year **deductible.**	65% after Calendar Year **deductible**
Durable Medical and Surgical Equipment	100% after the Calendar Year **deductible**	65% after the Calendar Year **deductible**
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) *(*Excluding Temporomandibular Joint (TMJ))*	100% after Calendar Year **deductible**	65% after Calendar Year **deductible**
Prosthetic Devices	100% per item after Calendar Year **deductible**	65% per item after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	100% after Calendar Year **deductible**	65% after Calendar Year **deductible**
Infusion Therapy	100% after Calendar Year **deductible**	65% after Calendar Year **deductible**
Radiation Therapy	100% after Calendar Year **deductible.**	65% after Calendar Year **deductible**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorder		
	100% after Calendar Year **deductible**	65% after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical and Occupational Therapy only	100% after Calendar Year **deductible**	65% after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Speech Therapy only	100% after Calendar Year **deductible**	65% after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	100% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**
Spinal Manipulation Maximum visits per Calendar Year	28 visits	28 visits

Pharmacy Benefit

Copays (Applicable to Preventive Prescription Drugs only) - All other drugs are subject to Calendar Year deductible.

PER PRESCRIPTION COPAY	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$15	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	$30	Not Covered
Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$30	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	$60	Not Covered
Non-Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$15	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	$30	Not Covered

Non-Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$45	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	$90	Not Covered

Diabetic prescription drugs, supplies and insulin		
For each 30 day supply filled at a retail **pharmacy**	0	Not Covered

If a **prescriber** prescribes a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost sharing for the **brand-name prescription drug**.

Preventive Care Drugs and Supplements		
Preventive care drugs and supplements filled at a **pharmacy** with a **prescription**: 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.	100% per item. No **copay** or **deductible** applies.	Not Covered.
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. Maximums: Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in	100% per supply No **copay** or **deductible** applies.	Not covered.

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.

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**; or
- 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 devices and
  - FDA-approved female brand-name emergency contraceptives, that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** unless you are granted a medical exception.

Coinsurance

	NETWORK	**OUT-OF-NETWORK**
Prescription Drug Plan Coinsurance	100% of the **negotiated charge**	Not Covered

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.

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**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Network Provider Calendar Year **Deductible**

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

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

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

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

Out-of-Network Provider Calendar Year **Deductible**

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

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

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

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar 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
This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Payment Provisions

Payment Percentage
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

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 **Maximum Out-of-Pocket Limit**. As to the individual **Maximum Out-of-Pocket Limit**, each of you must meet your **Maximum Out-of-Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out-of-Pocket Limit**. See list below.

Network Provider Maximum Out-of-Pocket Limit

Individual
Once the amount of eligible **network provider** expenses you or your covered dependents 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 Maximum Out-of-Pocket Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out-of-Pocket Limit,** these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

> Two family members have individually satisfied their individual **network provider Maximum Out-of-Pocket Limit** in a Calendar Year. Once these family members have each satisfied their individual **network provider Maximum Out-of-Pocket Limit**, the individual **network provider Maximum Out-of-Pocket Limit** is considered met for the remaining family members for the rest of the Calendar Year.

Out-of Network Provider Maximum Out-of-Pocket Limit

Individual
Once the amount of eligible **out-of-network provider** expenses you or your covered dependents 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 Maximum Out-of-Pocket Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **out-of-network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **out-of-network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **out-of-network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

> Two family members have individually satisfied their individual **out-of-network provider Maximum Out-of-Pocket Limit** in a Calendar Year. Once these family members have each satisfied their individual **out-of-network provider** Maximum Out-of-Pocket Limit, the individual **out-of-network provider Maximum Out-of-Pocket Limit** is considered met for the remaining family members for the rest of the Calendar Year.

The **Maximum Out-of-Pocket Limit** applies to both network and out -of-network 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**.

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 that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

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.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.