Schedule of Benefits

Employer: **County of El Paso**

MSA: 866233

Effective Date: January 1, 2018
Schedule: 1A
Booklet Base: 1

For: Aetna Choice POS II (Core Option Plan)

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$1,250	$2,500
Family Deductible*	$2,500	$5,000
Per Admission Copayment	$200 per admission	Not Applicable

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Maximum Out of Pocket Limit includes plan **deductible** and **copayments**.

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

Individual Maximum Out of Pocket Limit:

- For **network** expenses: $4,750

Family Maximum Out of Pocket Limit:

- For **network** expenses: $9,500

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 Calendar Year **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 but less than 65: Maximum Visits per 12 consecutive months	1 visit	Not Covered
Covered Persons age 65 and over: Maximum Visits per 12 consecutive months	1 visit	Not Covered
Preventive Care Immunizations *Performed in a facility or **physician's** office*	100% per visit No **copay** or Calendar Year **deductible** applies.	Not Covered
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	100% per visit No **copay** or Calendar year **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 Calendar Year **deductible** applies.	65% per visit after Calendar Year **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 Calendar Year **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 Covered
*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*.		

Voluntary Sterilization for Males		
Outpatient	80% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**
UMC Outpatient Facility	95% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**
El Paso Children's Hospital	95% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**
Physician Office	$40 per visit **copay** then the plan pays 80%	65% per visit after Calendar Year **deductible**
Family Planning - Female Voluntary Sterilization		
Inpatient	100% per visit No Calendar Year **deductible applies**	65% per visit after Calendar Year **deductible.**
Outpatient	100% per visit No 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 (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 Calendar Year **deductible** applies.	65% per prescription or refill after Calendar Year **deductible**.
Female Contraceptive Devices (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided) 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.]*	100% per prescription or refill No Calendar Year **deductible** applies.	65% per prescription or refill 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**	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	65% per visit after Calendar Year **deductible**
Alternatives to Physicians' Office Visits		
E-Visit Online or Telephonic Consultation by a PCP	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Specialist Office Visits	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	65% per visit after Calendar Year **deductible**
Alternative to Specialist Office Visit		
E-visits Online or Telemedicine Consultation by a Specialist	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Physician Office Visits-Surgery	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	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	100% per visit	65% per visit after Calendar Year

Services for Tobacco Use	No **copay** or Calendar Year **deductible** applies.	**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 visit 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
***Important Note**: Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.		
All Other Services	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	65% per visit after Calendar Year **deductible**
Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**
Administration of Anesthesia	80% per procedure after Calendar Year **deductible**	65% per procedure after Calendar Year **deductible**
Allergy Injections	80% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility and Physician	$250 **copay** per visit after the Calendar Year **deductible** then the plan pays 80%	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	$250 **copay** per visit after the Calendar Year **deductible** then the plan pays 80%	$250 **copay** per visit after the Calendar Year **deductible** then the plan pays 50%

Important Notice:
A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived.

Covered expenses that are applied to the emergency room **deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to any of your plan's other **deductibles** or **copays** cannot be applied to the emergency room **deductible** or **copay**.

Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	$40 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	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

Important Notice:
A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care copay/deductible** cannot be applied to any other **copay/deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay/deductible**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Performed at a UMC Outpatient Facility	95% per test after Calendar Year **deductible after $150 copay**	65% per test after Calendar Year **deductible**
Performed at an El Paso Children's Hospital Out Patient Facility	95% per test after Calendar Year **deductible after $150 copay**	65% per test after Calendar Year **deductible**
Performed at a Hospital Outpatient Facility	80% per test after Calendar Year **deductible after $150 copay**	65% per test after Calendar Year **deductible**
Performed at any other Facility	80% per test after Calendar Year **deductible**	65% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing		
Performed in a Physician's office	80% per procedure after Calendar Year **deductible**	65% per procedure after Calendar Year **deductible**
Performed at a Hospital Outpatient Facility	80% per procedure after Calendar Year **deductible after $150 copay**	65% per procedure after Calendar Year **deductible**
Performed at a UMC Outpatient Facility	95% per procedure after Calendar Year **deductible after $150 copay**	
Performed at an El Paso Children's Hospital Out Patient Facility	95% per test after Calendar Year **deductible after $150 copay**	65% per test after Calendar Year **deductible**
Performed at any other Facility	80% per procedure after Calendar Year **deductible**	65% per procedure after Calendar Year **deductible**
Preform at a Preferred Lab	100% No Calendar Year **deductible** applies	65% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)		
Performed in a Physician's office	$40 **copay** per visit then the plan pays 100%	65% per procedure after Calendar Year **deductible**
Performed at a Hospital Outpatient Facility	80% per procedure after Calendar Year **deductible after $150 copay**	65% per procedure after Calendar Year **deductible**
Performed at a UMC Outpatient Facility	95% per procedure after Calendar Year **deductible after $150 copay**	65% per procedure after Calendar Year **deductible**
Performed at an El Paso Children's Hospital Out Patient Facility	95% per test after Calendar Year **deductible after $150 copay**	65% per test after Calendar Year **deductible**
Performed at any other Facility	80% per procedure after Calendar Year **deductible**	65% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery performed at a Hospital	$150 per visit **copay** after Calendar Year **deductible** then the plan pays 80%	65% per visit/surgical procedure after Calendar Year **deductible**
Outpatient Surgery performed at UMC Facility	$150 per visit **copay** after Calendar Year **deductible** then the plan pays 95%	65% per visit/surgical procedure after Calendar Year **deductible**
Outpatient surgery performed at an El Paso Children's Hospital facility	$150 per visit **copay** after Calendar Year **deductible** then the plan pays 95%	65% per visit/surgical procedure after Calendar Year **deductible**
Outpatient Surgery performed at an Ambulatory Center or any other facility	80% after Calendar Year **deductible**	65% per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Hospital Facility Expenses Room and Board (including maternity)	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	65% per admission after Calendar Year **deductible**
UMC Facility Expenses Room and Board (including maternity)	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 95%	65% per admission after Calendar Year **deductible**
El Paso Children's Hospital Facility Expenses Room and Board (excluding maternity)	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 95%	65% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	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)	80% per visit after the Calendar Year **deductible**	65% per visit after the Calendar Year **deductible**

Private Duty Nursing (Outpatient)	80% per visit after the Calendar Year **deductible**	65% per visit after the Calendar Year **deductible**

Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	80% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**
Hospice Care - Other Expenses during a stay	80% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days
Hospice Outpatient Visits	80% 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.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Inpatient Treatment of Mental Disorders		
MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	65% per admission after Calendar Year **deductible**
UMC Facility Expenses	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 95%	65% per admission after Calendar Year **deductible**
El Paso Children's Hospital Expenses	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 95%	65% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**
Physician Services	80% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**

Inpatient Residential Treatment Facility Expenses	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	65% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	80% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**
UMC Inpatient Residential Treatment Facility Expenses	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 95%	65% per visit after Calendar Year **deductible**
El Paso Children's Hospital Residential Treatment Facility Expenses	$200 per visit copay after Calendar Year **deductible** then the plan pays 95%	65% per visit after Calendar Year **deductible**
Outpatient Treatment Of Mental Disorders		
Office visits	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	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	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	65% per admission after the Calendar Year **deductible**
UMC Facility Expenses	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 95%	65% per admission after Calendar Year **deductible**
El Paso Children's Hospital Expenses	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 95%	65% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**	65% per admission after Calendar Year **deductible**
Physician Services	80% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**

Inpatient Residential Treatment Facility Expenses	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	65% per admission after Calendar Year **deductible**
Inpatient UMC Residential Treatment Facility Expenses	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 95%	65% per admission after Calendar Year **deductible**
Inpatient El Paso Children's Hospital Treatment Facility Expenses	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 95%	65% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	80% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**

Outpatient Treatment of Substance Abuse		
Office visits	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	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	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 80%.	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	65% per admission after Calendar Year **deductible**.
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Ground, Air or Water Ambulance	80% after Calendar Year **deductible**	80% after Calendar Year **deductible**
Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Durable Medical and Surgical Equipment	80% per item after the Calendar Year **deductible**	65% per item after the Calendar Year **deductible**

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) *(Excluding Temporomandibular Joint (TMJ))*	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Prosthetic Devices	80% per item after Calendar Year **deductible**	65% per item after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorder		
	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical and Occupational Therapy only	80% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Speech Therapy only	80% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	80% per visit after Calendar Year **deductible**	65% per visit after Calendar Year **deductible**
Spinal Manipulation Maximum visits per Calendar Year performed by a Chiropractor	28 visits	28 visits

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$15	$15
For more than a 30 day supply but less than a 91 day supply (mail order)	$30	Not Applicable
Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$30	$30
For more than a 30 day supply but less than a 91 day supply (mail order)	$60	Not Applicable
Non-Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$15	$15
For more than a 30 day supply but less than a 91 day supply (mail order)	$30	Not Applicable
Non-Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$45	$45
For more than a 30 day supply but less than a 91 day supply (mail order)	$90	Not Applicable

Diabetic prescription drugs, supplies and insulin		
For each 30 day supply filled at a retail **pharmacy**	$0	$0

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 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	100% per supply No **copay** or **deductible** applies.	Not covered.

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**	65% 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.

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 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 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.

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.

Per Admission Copayment
A Per Admission **Copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility. A **copayment** 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.

Separate **copayments** may apply per facility. These **copayments** are in addition to any other **copayments** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

Covered expenses applied to the per admission **copayment** cannot be applied to any other **copayment** required in your plan. Likewise, **covered expenses** applied to your plan's other **copayments** cannot be applied to meet the per admission **copayment**.

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:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of-Pocket Limit** amount in a 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:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **out-of-network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **out-of-network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

The **Maximum Out-of-Pocket Limit** applies to both network and out -of-network benefits. You have separate **Maximum Out-of-Pocket Limit** for in-network and out-of-network benefits. **Maximum Out-of-Pocket 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.

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 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**.

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.