

Choice POS II Medical Plan

Schedule of Benefits

Prepared exclusively for:

Employer:	Millard Public Schools
Contract number:	MSA-737381 Schedule of Benefits 1A
Plan effective date:	January 1, 2020
Plan issue date:	February 14, 2020

These benefits are not insured with Aetna but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Aetna medical benefits plan.

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/payment percentage**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/payment percentage** and any limits that apply to the services.

How to read your schedule of benefits

- When we say:
 - “In-network coverage”, we mean you get care from a **network provider**.
 - “Out-of-network coverage”, we mean you can get care from **providers** who are not **network providers**.
- The **deductibles** and **copayments/payment percentage** listed in the schedule of benefits below reflect the **deductibles** and **copayment/payment percentage** amounts under your plan.
- Any **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the amount the Plan pays. You are responsible to pay any **deductibles, copayments**, and the remaining **payment percentage**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums. They are combined maximums between **network providers** and **out-of-network providers** unless we state otherwise.
- At the end of this schedule you will find detailed explanations about your:
 - **Deductible**
 - **Maximum out-of-pocket limits**
 - **Maximums**

Important note:

All **covered benefits** are subject to the Calendar Year **deductible** and **copayment/payment percentage** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna secure member website at www.aetna.com or at the toll-free number on your ID card.

This schedule of benefits replaces any schedule of benefits previously in effect under your plan of benefits. Keep this schedule of benefits with your booklet.

Plan features	Deductible/Maximums	
	In-network coverage*	Out-of-network coverage*
Deductible		
You have to meet your Calendar Year deductible before this plan pays for benefits.		
Individual	\$1,050 per Calendar Year	\$2,100 per Calendar Year
Family	\$2,100 per Calendar Year	\$4,200 per Calendar Year
Deductible waiver		
The Calendar Year in-network deductible is waived for all of the following eligible health services :		
<ul style="list-style-type: none"> • Preventive care and wellness • Family planning services - female contraceptives 		
Maximum out-of-pocket limit		
Maximum out-of-pocket limit per Calendar Year.		
Individual	\$5,000 per Calendar Year	\$10,000 per Calendar Year
Family	\$10,000 per Calendar Year	\$20,000 per Calendar Year
Precertification covered benefit reduction		
This only applies to out-of-network coverage. The booklet contains a complete description of the precertification program. You will find details on precertification requirements in the <i>Medical necessity and precertification requirements</i> section.		
Failure to precertify your eligible health services when required will result in the following benefits reduction:		
<ul style="list-style-type: none"> • A \$400 benefit reduction will be applied separately to each type of eligible health services or • The eligible health services will not be covered. 		
The additional percentage or dollar amount of the recognized charge which you may pay as a penalty for failure to obtain precertification is not a covered benefit , and will not be applied to the deductible amount or the maximum out-of-pocket limit , if any.		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
Preventive care and wellness		
Routine physical exams		
Performed at a physician's, PCP office	100% per visit No deductible applies	55% (of the recognized charge) per visit
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per Calendar Year	1 visit	1 visit
Covered persons age 65 and over: Maximum visits per Calendar Year	1 visit	1 visit
Preventive care immunizations		
Performed in a facility or at a physician's office	100% per visit No deductible applies	55% (of the recognized charge) per visit
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Well woman preventive visits routine gynecological exams (including pap smears)		
Performed at a physician's, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No deductible applies	55% (of the recognized charge) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	1 visit
Preventive screening and counseling services		
Office visits • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	100% per visit No deductible applies	55% (of the recognized charge) per visit
Obesity and/or healthy diet counseling maximums:		
Maximum visits per 12 months (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these, only <i>10</i> 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)*	26 visits (however, of these, only <i>10</i> 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)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Misuse of alcohol and/or drugs maximums:		
Maximum visits per 12 months	5 visits*	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Use of tobacco products maximums:		
Maximum visits per 12 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 infection counseling maximums:		
Maximum visits per 12 months	2 visits*	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.		
Genetic risk counseling for breast and ovarian cancer maximums:		
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations
Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)		
Routine cancer screenings	100% per visit No deductible applies	55% (of the recognized charge) per visit
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> 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 your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age, family history, and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> 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 your Aetna's secure member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening per Calendar Year*	1 screening per Calendar Year*
<p>*Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.</p>		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Prenatal care		
Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
Preventive care services only	100% per visit No deductible applies	55% (of the recognized charge) per visit
Important note: You should review the <i>Maternity and related newborn care</i> sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services – facility or office visits	100% per visit No deductible applies	55% (of the recognized charge) per visit
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits*	6 visits*
*Important note: Any visits that exceed the lactation counseling services maximum are covered under Physician services office visits.		
Breast feeding durable medical equipment		
Breast pump supplies and accessories	100% per item No deductible applies	55% (of the recognized charge) per item
Important note: See the <i>Breast feeding durable medical equipment</i> section of the booklet for limitations on breast pump and supplies.		
Family planning services – female contraceptives		
Counseling services		
Female contraceptive counseling services office visit	100% per visit No deductible applies	55% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*	2 visits*
*Important note: Any visits that exceed the contraceptive counseling services maximum are covered under Physician services office visits.		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Devices		
Female contraceptive device provided, administered, or removed, by a physician during an office visit	100% per item No deductible applies	55% (of the recognized charge) per item
Female voluntary sterilization		
Inpatient	100% per admission No deductible applies	55% (of the recognized charge) per admission
Outpatient	100% per visit No deductible applies	55% (of the recognized charge) per visit
Eligible health services	In-network coverage*	Out-of-network coverage*
Physicians and other health professionals		
Physicians and specialists office visits (non-surgical)		
Physician services		
Office hours visits (non-surgical) non preventive care	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
*Telemedicine Consultations		
<i>*The plan may utilize one or more telemedicine vendors. To obtain information regarding potential cost share when utilizing a telemedicine vendor, contact member services at the number on your ID card.</i>		
Immunizations that are not considered preventive care		
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specialist		
Specialist office visits		
Office hours visits (non-surgical)	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Physician surgical services		
Physicians and specialists office visits		
Performed at a physician's, PCP office	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Performed at a specialist's office	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Alternatives to physician office visits		
Walk-in clinic visits		
Walk-in clinic non-emergency visit <i>(includes coverage for immunizations)</i>	75% (of the negotiated charge) per visit	Not covered
	<p>Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.</p> <p>For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.</p>	Not applicable

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
Hospital and other facility care		
Hospital care		
Inpatient hospital	75% (of the negotiated charge) per admission	55% (of the recognized charge) per admission
Alternatives to hospital stays		
Outpatient surgery and physician surgical services		
	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Home health care		
Outpatient	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Maximum visits per Calendar Year	60 Limited to: 3 intermittent visits per day provided by a participating home health care agency ; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge	60 Limited to: 3 intermittent visits per day provided by a participating home health care agency ; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge
Hospice care		
Inpatient facility	75% (of the negotiated charge) per admission	55% (of the recognized charge) per admission
Maximum days per lifetime	Unlimited	Unlimited
Hospice care		
Outpatient	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
	Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day	Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Skilled nursing facility		
Inpatient facility	75% (of the negotiated charge) per admission	55% (of the recognized charge) per admission
Maximum days per Calendar Year	120	120
Eligible health services	In-network coverage*	Out-of-network coverage*
Emergency services and urgent care		
Emergency services		
Hospital emergency room	\$100 then the plan pays 75% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered
<p>Important Note:</p> <ul style="list-style-type: none"> As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (deductible, copayment 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 provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the member's ID number is on the bill. A separate hospital emergency room copayment/payment percentage will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/payment percentage will be waived and your inpatient copayment/payment percentage will apply. 		
Urgent care		
Urgent medical care (at a non- hospital free standing facility)	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Non-urgent use of urgent care provider (at a non- hospital free standing facility)	Not covered	Not covered

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
Specific conditions		
Autism spectrum disorder		
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other illness under this plan.		
Birth center		
Inpatient	75% (of the negotiated charge) per admission	55% (of the recognized charge) per admission
Family planning services - other		
Voluntary sterilization for males		
Outpatient	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Jaw joint disorder treatment		
Jaw joint disorder treatment	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Maternity and related newborn care		
Inpatient	75% (of the negotiated charge) per admission	55% (of the recognized charge) per admission
Delivery services and postpartum care services		
Performed in a facility or at a physician's office	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Mental health treatment - inpatient		
Inpatient mental health treatment Inpatient residential treatment facility Coverage is provided under the same terms, conditions as any other illness .	75% (of the negotiated charge) per admission	55% (of the recognized charge) per admission
Mental health treatment - outpatient		
Outpatient mental health treatment office visits to a physician or behavioral health provider includes telemedicine consultation Coverage is provided under the same terms, conditions as any other illness .	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Outpatient mental health treatment office visits to a physician or behavioral health provider includes telemedicine cognitive behavioral therapy consultation	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Other outpatient mental health treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive outpatient program The cost share doesn't apply to in-network peer	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

counseling support services		
Substance related disorders treatment - inpatient		
Inpatient substance abuse detoxification during a hospital confinement	75% (of the negotiated charge) per admission	55% (of the recognized charge) per admission
Inpatient substance abuse rehabilitation during a hospital confinement		
Inpatient residential treatment facility during a hospital confinement		
Coverage is provided under the same terms, conditions as any other illness .		
Substance related disorders treatment - outpatient: detoxification and rehabilitation		
Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine consultation)	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Coverage is provided under the same terms, conditions as any other illness .		
Outpatient substance abuse office visits to a physician or behavioral health provider includes telemedicine cognitive behavioral therapy consultations	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Coverage is provided under the same terms, conditions as any other illness .		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Other outpatient substance abuse services	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Partial hospitalization treatment		
Intensive outpatient program		
The cost share doesn't apply to in-network peer counseling support services.		

Oral and maxillofacial treatment (mouth, jaws and teeth)		
Oral and maxillofacial treatment (mouth, jaws and teeth)	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit

Reconstructive breast surgery		
Reconstructive breast surgery	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Reconstructive surgery and supplies		
Reconstructive surgery	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	Network (IOE facility)	Network (Non-IOE facility)	Out-of-network coverage*
---------------------------------	-------------------------------	-----------------------------------	---------------------------------

Transplant services facility and non-facility			
Inpatient hospital transplant services	75% (of the negotiated charge) per transplant	No coverage	No coverage
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	No coverage	No coverage

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
Treatment of infertility		
Basic infertility		
Basic infertility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Eligible health services		
In-network coverage*		
Out-of-network coverage*		
Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services		
	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Diagnostic lab work		
	75% (of the negotiated charge) per visit.	55% (of the recognized charge) per visit.
Diagnostic radiological services		
	75% (of the negotiated charge) per visit.	55% (of the recognized charge) per visit.
Chemotherapy		
Chemotherapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient infusion therapy		
	75% (of the negotiated charge) per visit.	55% (of the recognized charge) per visit.
Outpatient radiation therapy		
Radiation therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation		
Cardiac rehabilitation	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Pulmonary rehabilitation		
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Short-term rehabilitation services		
Outpatient Physical, Occupational and Speech Therapies		
	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Maximum visits per Calendar Year	60	60
Habilitation therapy services		
	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
Other services		
Acupuncture		
Acupuncture	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Ambulance service		
Ground, air or water ambulance	75% (of the negotiated charge) per trip No deductible applies.	75% (of the recognized charge) per trip No deductible applies.
Clinical trial therapies (experimental or investigational)		
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Clinical trials (routine patient costs)		
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Durable medical equipment (DME)		
DME	75% (of the negotiated charge) per item	55% (of the recognized charge) per item
Hearing aids and exams		
Hearing aid exams	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Hearing aids	75% (of the negotiated charge) per item	55% (of the recognized charge) per item
Maximum per 4 Year period	\$3,000	\$3,000
Prosthetic devices		
Prosthetic devices	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Spinal manipulation		
Spinal manipulation	75% (of the negotiated charge) per visit	55% (of the recognized charge) per visit
Maximum visits per Calendar Year	36	36

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
Outpatient prescription drugs		
Plan features	Deductible/Copayment/Payment Percentage/Maximums	
Deductible waiver		
The Calendar Year deductible is waived for all prescription drugs .		
Deductible and copayment/payment percentage waiver for risk reducing breast cancer prescription drugs		
The Calendar Year deductible and the per prescription copayment/payment percentage will not apply to risk reducing breast cancer prescription drugs when obtained at a network pharmacy . This means that such risk reducing breast cancer prescription drugs will be paid at 100%.		
Deductible and copayment/payment percentage waiver for tobacco cessation prescription and over-the-counter drugs		
The Calendar Year deductible and the per prescription copayment/payment percentage will not apply to 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%.		
Deductible and copayment/payment percentage waiver for contraceptives		
The Calendar Year deductible and the per prescription copayment/payment percentage will not apply to female contraceptive methods when obtained at a network pharmacy . This means that the following will be paid at 100%:		
<ul style="list-style-type: none"> • Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drugs for that method paid at 100%. 		
The Calendar Year deductible and the per prescription copayment/payment percentage continue to apply to prescription drugs that have a generic equivalent or generic alternative available within the same therapeutic drug class obtained at a network pharmacy unless you are granted a medical exception.		
Important note:		
Review the <i>How to access out-of-network pharmacies</i> section of the booklet for more information on how these pharmacies are subject to higher out-of-pocket costs.		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Generic prescription drugs		
Per prescription copayment/payment percentage		
For each fill up to a 30 day supply filled at a retail pharmacy	<p>\$25 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	<p>\$25 deductible per supply</p> <p>Payment percentage is 75% (of the recognized charge)</p> <p>No Calendar Year deductible applies</p>
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy and a CVS pharmacy	<p>\$62.50 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	Not covered
Preferred brand-name prescription drugs		
Per prescription copayment/payment percentage		
For each fill up to a 30 day supply filled at a retail pharmacy	<p>\$80 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	<p>\$80 deductible per supply</p> <p>Payment percentage is 75% (of the recognized charge)</p> <p>No Calendar Year deductible applies</p>
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy and a CVS pharmacy	<p>\$200 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	Not covered
Non-preferred brand-name prescription drugs		
Per prescription copayment/payment percentage		
For each fill up to a 30 day supply filled at a retail pharmacy	<p>\$110 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	<p>\$110 deductible per supply</p> <p>Payment percentage is 75% (of the recognized charge)</p> <p>No Calendar Year deductible applies</p>
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy and a CVS pharmacy	<p>\$275 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	Not covered

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Preferred diabetic supplies		
Per prescription copayment/payment percentage		
For each fill up to a 30 day supply filled at a retail pharmacy	<p>\$5 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	Not covered
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	<p>\$12.50 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	Not covered
Non-preferred diabetic supplies		
Per prescription copayment/payment percentage		
For each fill up to a 30 day supply filled at a retail pharmacy	<p>\$75 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	Not covered
More than a 30 day supply but less than a 91 day supply filed at a mail order pharmacy	<p>\$187.50 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	Not covered
Brand-name specialty drugs		
Per prescription copayment/payment percentage		
For each fill up to a 30 day supply filled at a retail pharmacy	<p>\$175 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	Not covered
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a pharmacy	100% per prescription or refill	Not covered

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Maximums:	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 Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	
-----------	--	--

Risk reducing breast cancer prescription drugs

Risk reducing breast cancer prescription drugs filled at a pharmacy	100% per prescription or refill	Not covered
---	--	-------------

Maximums:	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 Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	
-----------	--	--

Tobacco cessation prescription and over-the-counter drugs

Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy	\$0 per prescription or refill No deductible applies	Not covered
---	---	-------------

Maximums:	Coverage is permitted for two 90-day treatment regimens only. 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	
-----------	--	--

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

	cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	

If you or your **prescriber** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between **the generic prescription drug** and the **brand-name prescription drug**, plus the cost sharing that applies to the **brand-name prescription drug**.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Maximum out-of-pocket limits**
- **Maximums**

that are listed in the first part of this schedule of benefits.

Deductible provisions

Eligible health services applied to the out-of-network **deductibles** will be applied to satisfy the in-network **deductibles**. **Eligible health services** applied to the in-network **deductibles** will be applied to satisfy the out-of-network **deductibles**.

The **deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments/payment percentage** for **eligible health services** to which the **deductible** does not apply.

Individual

This is the amount you owe for in-network and out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

Family

This is the amount you and your covered dependents owe for in-network and out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you and your covered dependents pay for **eligible health services** reach this family Calendar Year **deductible**, this plan will begin to pay for **eligible health services** that you and your covered dependents incur for the rest of the Calendar Year.

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

- The combined **eligible health services** 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

Copayment

As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Payment percentage

The specific percentage the plan pays for a health care service listed in the schedule of benefits.

Maximum out-of-pocket limits provisions
--

Eligible health services that are subject to the maximum out-of-pocket limit include prescription drug eligible health services provided under the medical plan outpatient prescription drug plan.
--

Eligible health services 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 eligible health services applied to the in-network maximum out-of-pocket limit will be applied to satisfy the out-of-network maximum out-of-pocket limit .

The maximum out-of-pocket limit is the maximum amount you are responsible to pay for copayments/payment percentage and deductibles for eligible health services during the Calendar Year. This plan has an individual and family 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.

Individual

Once the amount of the copayments/payment percentage and deductibles you and your covered dependents have paid for eligible health services during the Calendar Year meets the individual maximum out-of-pocket limit , this plan will pay 100% of the negotiated charge or recognized charge for covered benefits that apply toward the limit for the rest of the Calendar Year for that person.
--

Family

Once the amount of the copayments/payment percentage and deductibles you and your covered dependents have paid for eligible health services during the Calendar Year meets this family maximum out-of-pocket limit , this plan will pay 100% of the negotiated charge or recognized charge for such covered benefits that apply toward the limit for the remainder of the Calendar Year for all covered family members.
--

To satisfy this family maximum out-of-pocket limit for the rest of the Calendar Year, the following must happen:

- | |
|--|
| <ul style="list-style-type: none">• The family maximum out-of-pocket limit is a cumulative maximum out-of-pocket limit for all family members. The family 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 maximum out-of-pocket limit amount in a Calendar Year. |
|--|

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/payment percentage** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services
- All costs for non-emergency use of the emergency room
- All costs incurred for non-urgent use of an **urgent care provider**
- As it applies to out-of-network coverage: Charges, expenses or costs in excess of the **recognized charge**

Maximum provisions

Eligible health services applied to the **out-of-network** maximum will be applied to satisfy the network maximum and **eligible health services** applied to the network maximum will be applied to satisfy the **out-of-network** maximum.

Calculations; determination of recognized charge; determination of benefits provisions

Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.

Outpatient prescription drug maximum out-of-pocket limits provisions

Eligible health services that are subject to the **maximum out-of-pocket limit** include **eligible health services** provided under the medical plan and the outpatient **prescription drug** plan.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits