# Schedule of Benefits

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| **Employer:** | **Polk County, a Political Subdivision of the State of Florida** |
| **ASA:** | 811370 |
| **Issue Date:** | August 26, 2014 |
| **Effective Date:** | January 1, 2014 |
| **Schedule:** | 4A |
| **Booklet Base:** | 4 |

For: Choice POS II with Aetna HealthFund

## Aetna HealthFund *(GR-9N-S-06-01)*

### Plan Features

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|---|---|
| **Annual HealthFund Amount** | $300 Individual<br>$600 Individual and Spouse or children<br>$800 Family |
| ***Healthy Incentive Amount*** | $200 Individual |

**Schedule of Benefits**
The HealthFund benefit will pay 100% of eligible HealthFund expenses (**network** and **out-of-network**). It will also reduce your individual or family **deductible**. Once your maximum HealthFund benefit is paid, you will be responsible for covered expenses until any remaining **deductible** is met. Once your **deductible** has been met, your health expense coverage will begin to pay for **covered expenses**.

**Aetna Choice POS II Medical Plan**

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Calendar Year Deductible*** | | |
| **Individual Deductible***<br>Employee Only | $1,500 | $3,250 |
| **Family Deductible***<br>Employee + Spouse or Children | $3,000 | $6,500 |
| Employee + Family | $4,500 | $9,750 |

*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: $3,150.
- For **out-of-network** expenses: $6,500.

**Individual and One Dependent Out of Pocket Limit**:

- For **network** expenses: $6,300.
- For **out-of-network** expenses: $13,000.

**Family Maximum Out of Pocket Limit:**

- For **network** expenses: $9,450.
- For **out-of-network** expenses: $19,500.

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| ***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***<br>***Office Visits*** | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% per visit after Calendar Year **deductible** |
| *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. | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. |
| *Covered Persons ages 22 and over* Maximum Visits per 12 consecutive months | 1 visit | 1 visit |
| ***Preventive Care Immunizations***<br>*Performed in a facility or* ***physician's*** *office* | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% per visit after Calendar Year **deductible** |

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|---|---|---|
| ***Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products*** | 100% per visits<br>No **copay** or **deductible** applies. | 60% per visits after Calendar Year **deductible** |
| *Obesity*<br>Maximum Visits per 12 consecutive months<br>*(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)* ***** | 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)* ***** |
| ***Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.*** | | |
| *Misuse of Alcohol and/or Drugs*<br>Maximum Visits per 12 consecutive months | 5 visits ***** | 5 visits ***** |
| ***Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.*** | | |
| *Use of Tobacco Products*<br>Maximum Visits per 12 consecutive months | 8 visits ***** | 8 visits ***** |
| ***Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.*** | | |
| ***Well Woman Preventive Visits***<br>***Office Visits*** | 100% per visit<br><br>No Calendar Year **deductible** applies. | 60% per visit after Calendar Year **deductible** |
| ***Well Woman Preventive Visits***<br>Maximum Visits per Calendar Year | 1 visit | 1 visit |

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|---|---|---|
| ***Hearing Exam*** | 100% per exam<br><br>No Calendar Year **deductible** applies. | 60% per exam after Calendar Year **deductible** |
| Maximum exams per 12 month period | 1 exam | 1 exam |
| ***Routine Cancer Screening Outpatient*** | 100% per visit<br><br>No Calendar Year **deductible** applies. | 60% per visit after Calendar Year **deductible** |
| 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.<br><br>*For details, contact your **physician,** log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.* | 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.<br><br>*For details, contact your **physician,** log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.* |
| ***Prenatal Care Office Visits*** | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% 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<br><br>No **copay** or **deductible** applies. | 60% per visit after Calendar Year **deductible** |
| Lactation Counseling Services Maximum Visits either in a group or individual setting | 6* visits per 12 months | Not Applicable |
| ***Important Note**: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*. | | |

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|---|---|---|
| **Breast Pumps & Supplies** | 100% per item.<br><br>No **copay** or **deductible** applies. | 60% per item after Calendar Year **deductible** |
| **Important Note**: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies. | | |

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| ***Family Planning Services*** | | |
| Female Contraceptive Counseling Services -Office Visits. | 100% per visit.<br><br>No **copay** or **deductible** applies. | 60% per visit after Calendar Year **deductible** |

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| 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.* | | |

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| ***Family Planning - Other*** | | |
| Voluntary Sterilization for Males | | |
| Outpatient | 80% per visit after Calendar Year **deductible.** | 60% per visit after Calendar Year **deductible.** |

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|---|---|---|
| ***Family Planning - Female Voluntary Sterilization*** | | |
| ***Inpatient*** | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% per visit after Calendar Year **deductible** |
| ***Outpatient*** | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% 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<br><br>No Calendar Year **deductible** applies. | 60% 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) | 100% per prescription or refill<br><br>No Calendar Year **deductible** applies. | 60% per prescription or refill after Calendar Year **deductible**. |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Physician Services*** | | |
| ***Office Visits to Primary Care Physician***<br>Office visits (non-surgical) to non-specialist | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |
| ***Specialist Office Visits*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |
| ***Physician Office Visits-Surgery*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |
| ***Walk-In Clinic Visit (Non-Emergency)*** | | |
| ***Preventive Care Services****<br>Immunizations | 100% per visit<br><br>No **copay** or **deductible** applies.<br><br>For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card. | 60% per visit after Calendar Year **deductible** |
| Individual Screening and Counseling Services for Tobacco Use | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% 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<br><br>No **copay** or **deductible** applies. | 60% 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 |
| ***Important Note**:<br>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**. | | |
| ***Stress Management Services****<br>Individual Screening and Counseling Services | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% per visits after Calendar Year **deductible** |

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| ***Important Note**:<br>Not all stress management 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*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |
| ***Physician Services for Inpatient Facility and Hospital Visits*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |
| ***Administration of Anesthesia*** | 80% per procedure after Calendar Year **deductible** | 60% per procedure after Calendar Year **deductible** |
| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** |
| ***Emergency Medical Services*** | | |
| ***Hospital Emergency Facility and Physician*** | 80% per visit after the Calendar Year **deductible** | 80% per visit after the Calendar Year **deductible**<br><br>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*** | Not covered | Not covered |
| ***Urgent Care Services*** | | |
| ***Urgent Medical Care***<br>*(at a non-hospital free standing facility)* | $50 per visit **copay** then the plan pays 100%<br><br>No Calendar Year **deductible** applies. | 60% per visit after Calendar Year **deductible** |
| ***Urgent Medical Care***<br>*(from other than a non-hospital free standing facility)* | Refer to *Emergency Medical Services* and *Physician Services* above. | Refer to *Emergency Medical Services* and *Physician Services* above. |

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| ***Non-Urgent Use of Urgent Care Provider***<br>*(at an Emergency Room or a non-hospital free standing facility)* | $50 per visit **copay** then the plan pays 100%<br><br>No Calendar Year **deductible** applies. | 60% per visit after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Outpatient Diagnostic and Preoperative Testing*** | | |
| ***Complex Imaging Services*** | | |
| ***Complex Imaging*** | 80% per test after Calendar Year **deductible** | 60% per test after Calendar Year **deductible** |
| ***Diagnostic Laboratory Testing*** | | |
| ***Diagnostic Laboratory Testing*** | 80% per procedure after Calendar Year **deductible** | 60% per procedure after Calendar Year **deductible** |
| ***Diagnostic X-Rays (except Complex Imaging Services)*** | | |
| ***Diagnostic X-Rays*** | 80% per procedure after Calendar Year **deductible** | 60% per procedure after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Outpatient Surgery*** | | |
| ***Outpatient Surgery*** | 80% per visit/surgical procedure after Calendar Year **deductible** | 60% 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***<br>Room and Board<br>(including maternity) | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| Other than Room and Board | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| For MIP Hysterectomies<br>(**M**inimally **I**nvasive **P**rocedure) | 90% per admission after Calendar Year deductible | 60% per admission after Calendar Year **deductible** |

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| ***Skilled Nursing Inpatient Facility*** | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| Maximum Days per Calendar Year | 90 days | 90 days |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Specialty Benefits*** | | |
| ***Home Health Care (Outpatient)*** | 80% per visit after the Calendar Year **deductible** | 60% per visit after the Calendar Year **deductible** |
| Maximum Visits per Calendar Year | Unlimited visits | Unlimited visits |
| ***Private Duty Nursing (Outpatient)*** | 80% per visit after the Calendar Year **deductible** | 60% per visit after the Calendar Year **deductible** |
| Maximum Visit Limit per *Calendar Year* | Unlimited | Unlimited |
| ***Hospice Benefits*** | | |
| ***Hospice Care - Facility Expenses*** (Room & Board) | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| ***Hospice Care - Other Expenses during a stay*** | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| Maximum Benefit per lifetime | Unlimited days | Unlimited days |
| ***Hospice Outpatient Visits*** | 80% per visit after Calendar Year **deductible** | 60% 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 | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| Other than Room and Board | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| Physician Services | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| ***Inpatient Residential Treatment Facility Expenses*** | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| ***Inpatient Residential Treatment Facility Expenses Physician Services*** | 80% after Calendar Year **deductible** | 60% after Calendar Year **deductible** |
| ***Outpatient Treatment Of Mental Disorders*** | | |
| ***Outpatient Services*** | 80% per visit after the Calendar Year **deductible** | 60% per visit after the Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Inpatient Treatment of Substance Abuse*** | | |
| ***Hospital Facility Expenses*** | | |
| Room and Board | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| Other than Room and Board | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| Physician Services | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| ***Inpatient Residential Treatment Facility Expenses*** | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| ***Inpatient Residential Treatment Facility Expenses Physician Services*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |

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|---|---|---|
| ***Outpatient Treatment of Substance Abuse*** | | |
| ***Outpatient Treatment*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Obesity Treatment Non Surgical*** | | |
| ***Outpatient Obesity Treatment (non surgical)*** | 80% per visit after the Calendar Year **deductible** | Not Covered |

| PLAN FEATURES | NETWORK (IOQ Facility) | OUT-OF-NETWORK (Network non-IOQ Facility or Out-of-Network Facility) |
|---|---|---|
| ***Obesity Treatment Surgical*** | | |
| ***Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)*** | 80% per admission after Calendar Year **deductible** | Not Covered |
| ***Outpatient Morbid Obesity Surgery*** | 80% per service after Calendar Year **deductible** | Not Covered |
| Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient) | Unlimited | Not Covered |

| PLAN FEATURES | NETWORK (IOE Facility) | NETWORK (Non-IOE Facility) | OUT-OF-NETWORK |
|---|---|---|---|
| ***Transplant Services Facility and Non-Facility Expenses*** | | | |
| ***Transplant Facility Expenses*** | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** | 60% 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*** | | |
| ***Acupuncture*** | Not Covered | Not Covered |
| ***Ground, Air or Water Ambulance*** | 80% after Calendar Year **deductible** | 60% after Calendar Year **deductible** |
| ***Durable Medical and Surgical Equipment*** | 80% per item after the Calendar Year **deductible** | 60% per item after the Calendar Year **deductible** |
| ***Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)*** | 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** | 60% 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 |
|---|---|---|
| ***Short Term Outpatient Rehabilitation Therapies*** *<11SECTION095>* | | |
| ***Outpatient Physical, Occupational and Speech Therapy combined*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Spinal Manipulation*** | | |
| | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |

## Expense Provisions

**The following provisions apply to your health expense plan.**
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

**KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.**

### Deductible Provisions

**Covered expenses** applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

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.

**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. **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**.

**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**;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

### Precertification Benefit Reduction

The Booklet contains a complete description of the **precertification** program. Refer to the "Understanding Precertification" section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- A $200 benefit reduction will be applied separately to each type of expense.

# General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.