

Schedule of Benefits

Employer: City Of Round Rock
 MSA: 819919
 Issue Date: May 12, 2014
 Effective Date: January 1, 2014
 Schedule: 1A
 Booklet Base: 1

For: Aetna Choice POS II - Aexcel Plus Plan

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	\$750	\$2,000
Family Deductible*	\$2,250	\$6,750

*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: \$3,000.
- For **out-of-network** expenses: \$12,000.

Family Maximum Out of Pocket Limit:

- For **network** expenses: \$9,000.
- For **out-of-network** expenses: \$36,000.

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

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Preventive Care Benefits		
Routine Physical Exams		
Office Visits	100% per visit No copay or deductible applies.	50% per visit after Calendar Year deductible
<i>Covered Persons through age 21: Maximum Age & Visit Limits</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the 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.
<i>Covered Persons ages 22 but less than 65: Maximum Visits per 12 consecutive months</i>	1 visit	1 visit
<i>Covered Persons age 65 and over: Maximum Visits per 12 consecutive months</i>	1 visit	1 visit
Preventive Care Immunizations		
<i>Performed in a facility or physician's office</i>	100% per visit No copay or deductible applies.	50% per visit after Calendar Year deductible
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products		
<i>Obesity Maximum Visits per 12 consecutive months (This maximum applies only to Covered Persons ages 22 & older.)</i>	100% per visits No copay or deductible applies.	50% per visits after Calendar Year deductible
	26 visits (<i>however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease</i>)*	26 visits (<i>however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease</i>)*
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		

Misuse of Alcohol and/or Drugs

Maximum Visits per 12 consecutive months	5 visits*	5 visits*
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***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

Use of Tobacco Products

Maximum Visits per 12 consecutive months	8 visits*	8 visits*
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***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.	50% per visit after Calendar Year deductible
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Well Woman Preventive Visits

Maximum Visits per Calendar Year	1 visit	1 visit
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Hearing Exam

\$45 exam copay then the plan pays 100%	50% per exam after Calendar Year deductible
No Calendar Year deductible applies.	

Maximum exams per 24 month period	1 exam	1 exam
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Hearing Supply Maximum per 12 month period	\$4,000	\$4,000
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Routine Cancer Screening

Outpatient	100% per visit No Calendar Year deductible applies.	50% per visit after Calendar Year deductible
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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. <i>For details, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.</i>	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. <i>For details, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.</i>
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Prenatal Care		
Office Visits	100% per visit No copay or deductible applies.	50% 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 deductible applies.	50% 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 <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .		

Breast Pumps & Supplies	100% per item. No copay or deductible applies.	50% per item after Calendar Year deductible
Important Note: Refer to the <i>Comprehensive Lactation Support and Counseling Services</i> section of the Booklet for limitations on breast pumps and supplies.		

Family Planning Services		
Female Contraceptive Counseling Services -Office Visits.	100% per visit. No copay or deductible applies.	50% per visit after Calendar Year deductible

Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	Not Applicable
*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .		

Family Planning - Other		
Voluntary Termination of Pregnancy Outpatient	80% per visit after Calendar Year deductible.	50% per visit after Calendar Year deductible.
Voluntary Sterilization for Males Outpatient	80% per visit after Calendar Year deductible.	50% per visit after Calendar Year deductible.

Family Planning - Female Voluntary Sterilization		
Inpatient	100% per visit No copay or deductible applies.	50% per visit after Calendar Year deductible
Outpatient	100% per visit No copay or deductible applies.	50% 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.	50% 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 No calendar year deductible applies.	50% 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	\$25 visit copay then the plan pays 100% No Calendar Year deductible applies.	50% per visit after Calendar Year deductible

Specialist Office Visits	\$45 visit copay then the plan pays 100%	50% per visit after Calendar Year deductible
	No Calendar Year deductible applies.	
Aexcel Designated Network Specialist	\$25 visit copay then the plan pays 100%	Not applicable
	No Calendar Year deductible applies.	
Non-Designated Network Specialist	\$45 visit copay then the plan pays 100%	Not applicable
	No Calendar Year deductible applies.	
Out of Network Provider Specialist	Not applicable	50% per visit after Calendar Year deductible

Physician Office Visits-Surgery		
for Physician	\$25 visit copay then the plan pays 100%	50% per visit after Calendar Year deductible
	No Calendar Year deductible applies.	
for Specialist	\$45 visit copay then the plan pays 100%	50% per visit after Calendar Year deductible
	No Calendar Year deductible applies.	
Aexcel Designated Network Specialist	\$25 visit copay then the plan pays 100%	Not applicable
	No Calendar Year deductible applies.	
Non-Designated Network Specialist	\$45 visit copay then the plan pays 100%	Not applicable
	No Calendar Year deductible applies.	
Out of Network Provider Specialist	Not applicable	50% per visit after Calendar Year deductible

Walk-In Clinic Visit (Non-Emergency)

Preventive Care Services*

Immunizations	100% per visit	50% per visit after Calendar Year deductible
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No **copay** or **deductible** applies.

For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.

Individual Screening and Counseling Services for Tobacco Use	100% per visit	50% per visit after Calendar Year deductible
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No **copay** or **deductible** applies.

Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services
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Individual Screening and Counseling Services for Obesity	100% per visit	50% per visit after Calendar Year deductible
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No **copay** or **deductible** applies.

Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services
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***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**.

Stress Management Services*

Individual Screening and Counseling Services	100% per visit	50% per visit after Calendar Year deductible
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No **copay** or **deductible** applies.

***Important Note:**

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	\$25 visit copay then the plan pays 100%	50% per visit after Calendar Year deductible
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No Calendar Year **deductible** applies.

Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible
Aexcel Designated Network Specialist	80% per visit after Calendar Year deductible	Not applicable
Non-Designated Network Specialist	80% per visit after Calendar Year deductible	Not applicable
Out of Network Provider Specialist	Not applicable	50% per visit after Calendar Year deductible
Administration of Anesthesia	80% per procedure after Calendar Year deductible	50% per procedure after Calendar Year deductible
Allergy Injections	80% per visit after Calendar Year deductible.	50% per visit after Calendar Year deductible.
Immunizations (when not part of the physical exam)	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
Emergency Medical Services		
Hospital Emergency Facility and Physician	\$200 copay per visit after the Calendar Year deductible then the plan pays 80%	\$200 deductible per visit after the Calendar Year deductible then the plan pays 50%
See Important Note Below		
<p>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.</p>		
Non-Emergency Care in a Hospital Emergency Room	\$200 copay per visit after the Calendar Year deductible then the plan pays 80%	\$200 deductible 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 <i>(at a non-hospital free standing facility)</i>	\$35 copay per visit then the plan pays 100%	50% per visit after Calendar Year deductible
	No Calendar Year deductible applies.	

Urgent Medical Care <i>(from other than a non-hospital free standing facility)</i>	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.
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Non-Urgent Use of Urgent Care Provider <i>(at an Emergency Room or a non-hospital free standing facility)</i>	Not covered	Not covered
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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
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Outpatient Diagnostic and Preoperative Testing**Complex Imaging Services**

Complex Imaging	80% per test after Calendar Year deductible	50% per test after Calendar Year deductible
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Diagnostic Laboratory Testing

Diagnostic Laboratory Testing	80% per procedure after Calendar Year deductible	50% per procedure after Calendar Year deductible
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Diagnostic X-Rays (except Complex Imaging Services)		
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Diagnostic X-Rays	80% per procedure after Calendar Year deductible	50% per procedure after Calendar Year deductible
Outpatient Surgery		
Outpatient Surgery	80% per visit/surgical procedure after Calendar Year deductible	50% per visit/surgical procedure after Calendar Year deductible
Inpatient Facility Expenses		
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible
Room and Board (including maternity)		
Other than Room and Board	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible
Skilled Nursing Inpatient Facility	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible
Maximum Days per Calendar Year	100 days	100 days
Specialty Benefits		
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Home Health Care (Outpatient)	80% per visit after the Calendar Year deductible	50% per visit after the Calendar Year deductible
Maximum Visits per Calendar Year	120 visits	120 visits
Private Duty Nursing (Outpatient)	80% per visit after the Calendar Year deductible	50% per visit after the Calendar Year deductible
Maximum Visit Limit per <i>Calendar Year</i>	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.

Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	100% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible
Hospice Care - Other Expenses during a stay	100% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible
Maximum Benefit per lifetime	Unlimited days	Unlimited days

Hospice Outpatient Visits	100% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible
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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	50% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible
Physician Services	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible

Inpatient Residential Treatment Facility Expenses	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible
Inpatient Residential Treatment Facility Expenses Physician Services	80% after Calendar Year deductible	50% after Calendar Year deductible

Outpatient Treatment Of Mental Disorders		
Outpatient Services	\$45 per visit copay then the plan pays 100%	50% per visit after the Calendar Year deductible
	No Calendar Year deductible applies	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Substance Abuse</i>		
<i>Hospital Facility Expenses</i>		
Room and Board	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible
Physician Services	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible
<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	80% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible

<i>Outpatient Treatment of Substance Abuse</i>		
<i>Outpatient Treatment</i>	\$45 per visit copay then the plan pays 100% No Calendar Year deductible applies	50% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Obesity Treatment Non Surgical</i>		
<i>Outpatient Obesity Treatment (non surgical)</i>	80% per visit after the Calendar Year deductible	50% per visit after the Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Obesity Treatment Surgical</i>		
<i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i>	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible

<i>Outpatient Morbid Obesity Surgery</i>	80% per service after Calendar Year deductible	50% per service after Calendar Year deductible
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Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Unlimited
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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	50% per admission after Calendar Year deductible	50% 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 in lieu of anesthesia	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.
Ground, Air or Water Ambulance	80% after Calendar Year deductible	80% after Calendar Year deductible
Durable Medical and Surgical Equipment	80% per item after the Calendar Year deductible	50% 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	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
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		
Outpatient Physical, Occupational and Speech Therapy combined	80% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year	60 visits	60 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	\$45 per visit copay then the plan pays 100%	50% per visit after Calendar Year deductible
	No Calendar Year deductible applies.	
Spinal Manipulation Maximum visits per Calendar Year	20 visits	20 visits

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	\$0	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	\$0	Not Covered
Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	\$30	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	\$50	Not Covered

Non-Preferred Generic Prescription Drugs

For each 30 day supply (retail)	\$0	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	\$0	Not Covered

Non-Preferred Brand-Name Prescription Drugs

For each 30 day supply (retail)	\$50	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	\$90	Not Covered

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**; contraceptive devices;
- 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 brand name 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
<i>Prescription Drug Plan Coinsurance</i>	100% of the negotiated charge	Not Covered

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

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 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*.

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.

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.

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;
- Any **covered expenses** which are payable by **Aetna** at 50%;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Precertification Benefit Reduction

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

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

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

General

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