Schedule of Benefits

Aetna Consumer Directed Health Plan (CDHP)
January 1, 2019

This is an ERISA plan, and you have certain rights under this plan. Please contact the Human Resources Benefits Team for additional information**. Certain services require precertification by Aetna. For details on the precertification process, as well as a list of services that require precertification see pages 6 through 8 in the CDHP SPD. If certain out-of-network services are not precertified, they will not be covered by Aetna.**

Aetna CDHP – The prescription drug coverage through Optum Rx, is integrated with your CDHP medical coverage. This means that your Optum Rx prescription drug plan costs will apply towards your CDHP annual deductible and calendar year out-of-pocket maximum. Therefore, you will pay for your non-preventive prescription drugs and medical plan costs until you have met the CDHP deductible. See the Prescription Plan SPD for information.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$1,500	$3,000
Family Deductible*	$3,000	$6,000

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

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

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

Individual Maximum Out of Pocket Limit:

- For **network** expenses: $3,000.
- For **out-of-network** expenses: $6,000.

Family Maximum Out of Pocket Limit:

- For **network** expenses: $6,000.
- For **out-of-network** expenses: $12,000.

Lifetime Maximum Benefit per person	Unlimited	Unlimited

For in-network services, you must first meet a deductible of $1,500 for individual coverage, or $3,000 for family coverage, with your medical and prescription expenses before the CDHP starts to pay for most covered services. There is no individual deductible when you elect family coverage. If one or more family members are covered in addition to yourself, you must reach the family deductible before coverage begins. However, there is an individual out-of-pocket maximum (OPM). Therefore, once any individual covered under the pan incurs expenses that exceed the individual OPM ($3,000), covered expenses for that individual will be reimbursed at 100% through the end of the calendar year, even if the full family OPM ($6,000) has not yet been met. The remaining family members would have to satisfy the remaining portion of the family OPM before their expenses are reimbursed at 100%.

The Payment Percentage (also referred to as coinsurance) listed in the Schedule below reflects what the CDHP 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**
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. Currently covers, seven exams in first 12 months of life, three exams the next 13 to 24 months, three exams the next 25 to 36 months, and one exam every calendar year thereafter.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Currently covers, seven exams in first 12 months of life, three exams the next 13 to 24 months, three exams the next 25 to 36 months, and one exam every calendar year thereafter.
Covered Persons ages 22 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* ***physician's*** *office*	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	100% per visit No **copay** or **deductible** applies.	50% per visits after Calendar Year **deductible**
Obesity Maximum Visits per Calendar Year	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy*	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy*

(This maximum applies only to Covered Persons ages 22 & older.)	*diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* *****	*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 Maximum Visits per Calendar Year	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 Maximum Visits per Calendar Year	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 ***Office Visits***	100% per visit No Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**
Well Woman Preventive Visits Maximum Visits per Calendar Year	1 visit	1 visit
Hearing Exam	80% per exam after Calendar Year **deductible**	50% per exam after Calendar Year **deductible**
Maximum exams per 12 month period	1 exam	1 exam
Hearing Supply Maximum per 3 year period	100% after Calendar Year **deductible** Covered up to a maximum of $1500 every 3 years	100% after Calendar Year **deductible** Covered up to a maximum $1500 every 3 years
Routine Cancer Screening ***Outpatient***	100% per visit No Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**

Routine Cancer Screening Maximums	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician,** log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.*	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician,** log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.*

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. Office visit to diagnose pregnancy covered at 90% after deductible for a preferred provider and 80% after deductible for a non-preferred provider, as well as post-partum 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 *Physician Services* office visit section of the *Schedule of Benefits*.		

Breast Pumps & Supplies	100% per item No **copay** or **deductible** applies	50% 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. Electric breast pump limited to 1 per 36 months.		

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 *Physician Services* office visit section of the *Schedule of Benefits*.		

Family Planning – Other		
Voluntary Termination of Pregnancy Outpatient	90% per visit for a preferred provider or 80% per visit for a non-preferred provider after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Voluntary Sterilization for Males Outpatient	90% per visit for a preferred provider or 80% per visit for a non-preferred provider 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 Contraceptive Administration (Covers office visit for injection of Depo-Provera and Lunell, Diaphragm filling, Cervical Cap, and IUD devices insertion/removal; see pharmacy benefit for additional contraceptive coverages)	100% per visit No Calendar Year **deductible** applies.	50% 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	80% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Specialist Office Visits	90% per visit for a preferred provider or 80% per visit for a non-preferred provider after Calendar Year **deductible** Note: Preferred Specialist categories are listed on page 4 of the **Aetna Consumer Directed Health Plan SPD**	50% per visit after Calendar Year **deductible**

Teladoc ***Network of board certified doctors that provide telephonic and video consults.*** ***Available24/7/365*** ***(855) 835-2362***	80% per visit after Calendar Year **Deductible** (you will pay no more than $40 per visit until deductible is met)	Not applicable; all Teladoc doctors are in-network
Physician Office Visits-Surgery Precertification is required.	Same as *Physician Services Specialist Office Visit* section in this Schedule of Benefits	50% per visit after Calendar Year **deductible**
Walk-In Clinic Visit (Non-Emergency)		
Preventive Care Services* Immunizations	100% per visit 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.	50% per visit after Calendar Year **deductible**
Individual Screening and Counseling Services for Tobacco Use	100% per visit No **copay** or **deductible** applies.	50% per visit after Calendar Year **deductible**
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services
Individual Screening and Counseling Services for Obesity	100% per visit No **copay** or **deductible** applies.	50% per visit after Calendar Year **deductible**
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services
***Important Note**: Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.		
All Other Services	80% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**

Physician Services for Inpatient Facility and Hospital Visits Precertification is required.	90% per visit for preferred provider or 80% per visit for non-preferred provider after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Administration of Anesthesia	80% per procedure after Calendar Year **deductible**	50% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility and Physician	100% per visit after the Calendar Year **deductible**	Paid the same as the Network level of benefits. See Important Note Below

Important Note: Please note that as these providers are not **network providers** and do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **payment percentage)**, as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

Non-Emergency Care in a Hospital Emergency Room	Not covered	Not covered
Urgent Care Services		
Urgent Care Provider	100% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Complex Imaging (High-Tech Radiology and Sleep Studies)	100% per procedure after Calendar Year **deductible** for utilizing an in-network independent facility. 80% per procedure after Calendar Year **deductible** for utilizing an in-network hospital setting. Nuclear medicine scan covered 100% after deductible any location.	No Coverage

Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	100% per procedure for utilizing Quest or Lab Corp., the preferred labs, after Calendar Year **deductible** 60% per procedure for non-preferred labs after Calendar Year **deductible**	No Coverage

Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	100% per procedure after Calendar Year **deductible** for utilizing an in-network independent facility. 80% per procedure after Calendar Year **deductible** for utilizing an in-network hospital setting.	No Coverage

Important note: High-tech radiology and x-ray procedures performed at an in-network hospital setting are considered medically necessary and covered at 100% per procedure after deductible for individuals who meet ANY of the following criteria:

- Less than 19 years of age
- Required obstetrical observation
- Require perinatology services
- Have a known contrast allergy
- Have a known chronic disease with prior radiology imaging procedures for the diagnosis, management or surveillance of the disease at the hospital outpatient department.
- Have pre-procedure imaging where the surgery or procedure is being performed at the hospital

An advanced radiologic imaging procedure in the hospital outpatient department is considered medically necessary when there are no geographically accessible appropriate alternative sites for the individual to undergo the procedure, including but not limited to the following:

- Moderate or deep sedation or general anesthesia is required for the procedure; or
- The equipment for the size of the individual is not available; or
- Open magnetic resonance imaging is required because the member has a documented diagnosis of claustrophobia and/or severe anxiety

An advanced radiologic imaging procedure in the hospital outpatient department is considered medically necessary when imaging in a physician's office or freestanding imaging center would reasonably be expected to delay care and adversely impact health outcome.

Pre-certification is required for high-tech radiology.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Outpatient Surgery		
Outpatient Surgery **Precertification is required**	80% per visit/surgical procedure after Calendar Year **deductible**	50% per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center **Precertification is required**	80% after Calendar Year **deductible**	50% after Calendar Year
Hospital Facility Expenses Room and Board (including maternity)	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Other than Room and Board Precertification is required	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility Precertification is required	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	60 Days	60 Days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care (Outpatient) Precertification is required	80% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	60 visits	60 visits
Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Hospice Care - Other Expenses during a stay Precertification is required	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Maximum Benefit per Calendar Year	180 days	180 days
Hospice Outpatient Visits Precertification is required	80% per visit after Calendar Year **deductible**	50% 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.	90% for preferred provider or 80% for non-preferred provider after Calendar Year **deductible**	50% after Calendar Year **deductible**

Comprehensive Infertility Expenses Proof of inability to conceive is not required	90% for preferred provider or 80% for non-preferred provider after Calendar Year **deductible**	50% after Calendar Year **deductible**
Artificial Insemination Maximum Benefit	6 courses of treatment per lifetime	6 courses of treatment per lifetime
Ovulation Induction Maximum Benefit	6 courses of treatment per lifetime	6 courses of treatment per lifetime
Maximum per lifetime	$20,000	$20,000
The Comprehensive Infertility services maximum per lifetime amount shown above **is combined with Advanced Reproductive Technology (ART) expenses**.		
Advanced Reproductive Technology (ART) Expenses Proof of inability to conceive is not required	90% for preferred provider or 80% for non-preferred provider after Calendar Year **deductible**	50% after Calendar Year **deductible**
Maximum per lifetime	3 courses of treatment per lifetime	3 courses of treatment per lifetime
	$20,000	$20,000
The Advanced Reproductive Technology (ART) Expenses Maximum per lifetime amount shown above is combined with Comprehensive Infertility expenses.		

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Inpatient Treatment of Mental Disorders		
MENTAL DISORDERS		
Hospital Facility Expenses **Precertification Required**		
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 **Precertification is required**	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services **Precertification is required**	80% after Calendar Year **deductible**	50% after Calendar Year **deductible**

Outpatient Treatment Of Mental Disorders		
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses **Precertification is required.**		
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 **Precertification is required.**	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services **Precertification is required.**	80% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Outpatient Treatment of Substance Abuse		
Outpatient Treatment	80% per visit after Calendar Year **deductible**	75% 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**	50% per visit after the Calendar Year **deductible**
Outpatient Services	80% per visit after the Calendar Year **deductible**	75% per visit after the Calendar Year **deductible**
Telemental Health – Video conference with licensed health provider. Call Inpathy at 800-442-8938. (If you reside outside NJ, NY or PA, call Aetna at 800-535-6689)	80% per visit after the Calendar Year **deductible**	Not applicable; all Telemental Health providers are in-network
Applied Behavioral Analysis (ABA) Therapy Coverage for children whose diagnosis is on the autism spectrum	80% per visit after the Calendar Year **deductible**	75% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Surgical		
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services) **Precertification is required.**	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Outpatient Morbid Obesity Surgery **Precertification is required.**	80% per service after Calendar Year **deductible**	50% per service after Calendar Year **deductible**
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Unlimited

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses **Precertification is required.**	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)	80% after Calendar Year **deductible**	50% after Calendar Year **deductible**	50% after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture 20 visits per Calendar Year	80% after Calendar Year **deductible**	50% after Calendar Year **deductible**
Ground, Air or Water Ambulance Covers medically necessary treatment or transport	100% after Calendar Year **deductible**	100% after Calendar Year **deductible**
Durable Medical and Surgical Equipment	80% per item after the Calendar Year **deductible**	Not Covered
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) Contact Aetna coverage details, only certain treatments covered through medical	80% after Calendar Year **deductible**	50% after Calendar Year **deductible**
Prosthetic Devices Limited to maximum reimbursement of $2500 ever three years for wig or wig repair. Covered based on medical necessity e.g., chemotherapy, radiation (combined in-network/out-of-network)	80% per item after Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	100% after Calendar Year **deductible**	50% after Calendar Year **deductible**
Infusion Therapy	100% after Calendar Year **deductible**	50% after Calendar Year **deductible**
Radiation Therapy	100% after Calendar Year **deductible**	50% after Calendar Year **deductible**
Dialysis Therapy	100% after Calendar Year **deductible**	50% after Calendar Year **deductible**

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**
Separate Physical, Occupational, Speech, cardiac and pulmonary Therapy Maximum visits per Calendar Year For Speech Therapy both Restorative and Non-Restorative services are covered.	100 visits	100 visits
	80 % per visit after Calendar Year deductible	50% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
Spinal Manipulation Maximum visits per Calendar Year. Services related to Physical Therapy acculmulate towards the 100 visit outpatient rehabiliation therapy maximum listed above.	20 visits	20 visits

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 SPD.

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.

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**;
- Non-covered expenses; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

General

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