



## Choice POS II Medical Plan

### Schedule of Benefits

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

**Prepared exclusively for:**

<b>Employer</b>	Tradesmen International
<b>Contract number:</b>	EH/MSA-100419
	Schedule of Benefits 1A
	Control number 868653 - Choice POS II
Plan effective date:	January 1, 2018
Plan issue date:	May 16, 2018

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

## Schedule of benefits

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

### How to read your schedule of benefits

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

#### **Important note:**

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

We are here to answer any questions. Contact Member Services by logging onto your Aetna Navigator® secure member website at [www.aetna.com](http://www.aetna.com) or at the toll-free number on your ID card.

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

Plan features	Deductible/Maximums	
	In-network coverage*	Out-of-network coverage*
<b>Deductible</b>		
You have to meet your Calendar Year <b>deductible</b> before this plan pays for benefits.		
Individual	\$2,000 per Calendar Year	\$4,000 per Calendar Year
Family	\$4,000 per Calendar Year	\$8,000 per Calendar Year
<b>Deductible waiver</b>		
The Calendar Year in-network <b>deductible</b> is waived for all of the following <b>eligible health services</b> :		
<ul style="list-style-type: none"> <li>• Preventive care and wellness</li> <li>• Family planning services - female contraceptives</li> </ul>		
<b>Maximum out-of-pocket limit</b>		
<b>Maximum out-of-pocket limit</b> per Calendar Year.		
Individual	\$5,000 per Calendar Year	\$10,000 per Calendar Year
Family	\$10,000 per Calendar Year	\$20,000 per Calendar Year
<b>Precertification covered benefit reduction</b>		
This only applies to out-of-network coverage. The booklet contains a complete description of the <b>precertification</b> program. You will find details on <b>precertification</b> requirements in the <i>Medical necessity and precertification requirements</i> section.		
Failure to <b>precertify</b> your <b>eligible health services</b> when required will result in the following benefits reduction:		
<ul style="list-style-type: none"> <li>• A \$400 benefit reduction will be applied separately to each type of <b>eligible health services</b> or</li> <li>• The <b>eligible health services</b> will not be covered.</li> </ul>		
The additional percentage or dollar amount of the <b>recognized charge</b> which you may pay as a penalty for failure to obtain <b>precertification</b> is not a <b>covered benefit</b> , and will not be applied to the <b>deductible</b> amount or the <b>maximum out-of-pocket limit</b> , if any.		

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

Eligible health services	In-network coverage*	Out-of-network coverage*
<b>Preventive care and wellness</b>		
<b>Routine physical exams</b>		
Performed at a <b>physician's, PCP</b> office	100% per visit  No <b>deductible</b> applies	Not covered
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna Navigator® secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	Not applicable
Covered persons age 22 and over but less than 65: Maximum visits per 12 months	1 visit	Not applicable
Covered persons age 65 and over: Maximum visits per 12 months	1 visit	Not applicable
<b>Preventive care immunizations</b>		
Performed in a facility or at a <b>physician's</b> office	100% per visit  No <b>deductible</b> applies	Not covered
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna Navigator® secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	Not applicable

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<b>Well woman preventive visits routine gynecological exams (including pap smears)</b>		
Performed at a <b>physician's, PCP,</b> obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit  No <b>deductible</b> applies	Not covered
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Not applicable
Maximum visits per Calendar Year	1 visit	Not applicable
<b>Preventive screening and counseling services</b>		
Office visits <ul style="list-style-type: none"> <li>• Obesity and/or healthy diet counseling</li> <li>• Misuse of alcohol and/or drugs</li> <li>• Use of tobacco products</li> <li>• Sexually transmitted infection counseling</li> <li>• Genetic risk counseling for breast and ovarian cancer</li> </ul>	100% per visit  No <b>deductible</b> applies	Not covered
<b>Obesity and/or healthy diet counseling maximums:</b>		
Maximum visits per 12 months  (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these, only <i>10</i> visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	Not applicable
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
<b>Misuse of alcohol and/or drugs maximums:</b>		
Maximum visits per 12 months	5 visits*	Not applicable
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		

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<b>Use of tobacco products maximums:</b>		
Maximum visits per 12 months	8 visits*	Not applicable
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
<b>Sexually transmitted infection counseling maximums:</b>		
Maximum visits per 12 months	2 visits*	Not applicable
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.		
<b>Genetic risk counseling for breast and ovarian cancer maximums:</b>		
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not applicable
<b>Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)</b>		
Routine cancer screenings	100% per visit No <b>deductible</b> applies	Not covered
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</li> <li>The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul> For details, contact your <b>physician</b> or Member Services by logging onto your Aetna Navigator® secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	Not applicable
Lung cancer screening maximums	1 screening every 12 months from age 55*	Not applicable
<p><b>*Important note:</b> Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.</p>		

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<b>Prenatal care</b>		
<b>Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)</b>		
Preventive care services only	100% per visit  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Important note:</b> You should review the <i>Maternity and related newborn care</i> sections. They will give you more information on coverage levels for maternity care under this plan.		
<b>Comprehensive lactation support and counseling services</b>		
Lactation counseling services – facility or office visits	100% per visit  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits*	Not applicable
<b>*Important note:</b> Any visits that exceed the lactation counseling services maximum are covered under <b>physician</b> services office visits.		
<b>Breast feeding durable medical equipment</b>		
Breast pump supplies and accessories	100% per item  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per item
<b>Important note:</b> See the <i>Breast feeding durable medical equipment</i> section of the booklet for limitations on breast pump and supplies.		
<b>Family planning services – female contraceptives</b>		
<b>Counseling services</b>		
Female contraceptive counseling services office visit	100% per visit  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*	Not applicable
<b>*Important note:</b> Any visits that exceed the contraceptive counseling services maximum are covered under <b>physician</b> services office visits.		

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<b>Devices</b>		
Female contraceptive device provided, administered, or removed, by a <b>physician</b> during an office visit	100% per item  No <b>deductible</b> applies	Not covered
<b>Female voluntary sterilization</b>		
Inpatient	100% per admission  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per admission
Outpatient	100% per visit  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>
<b>Physicians and other health professionals</b>		
<b>Physicians and specialists</b> office visits (non-surgical)		
<b>Physician services</b>		
Office hours visits (non-surgical) non preventive care	\$30 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
Complex imaging services, lab work and radiological services performed during a <b>physician's</b> office visit	\$30 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Allergy injections</b>		
Performed at a <b>physician's, PCP or specialist</b> office when you do not see the <b>physician</b>	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Immunizations that are not considered Preventive Care</b>		
Immunizations that are not considered Preventive Care	Covered according to the type of benefit and the place where the service is received.	Not covered
<b>Specialist</b>		
<b>Specialist office visits</b>		

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Office hours visits (non-surgical)	\$50 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
Complex imaging services, lab work and radiological services performed during a <b>specialist</b> office visit	\$50 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Physician surgical services</b>		
<b>Physicians and specialists</b> office visits		
Performed at a <b>physician's, PCP</b> office	\$30 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
Performed at a <b>specialist's</b> office	\$50 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Alternatives to physician office visits</b>		
<b>Walk-in clinic visits</b>		
<b>Preventive Care Services</b>		
Immunizations	100% per visit  No <b>deductible</b> applies	Not covered
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna Navigator® secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna Navigator® secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.

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<b>All non preventive care services for which cost sharing is not shown above</b>		
All other services	\$20 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No deductible applies	50% (of the <b>recognized charge</b> ) per visit
<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>
<b>Hospital and other facility care</b>		
<b>Hospital care</b>		
Inpatient <b>hospital</b>	\$200 then the plan pays 70% (of the balance of the <b>negotiated charge</b> ) per admission	\$400 then the plan pays 50% (of the balance of the <b>recognized charge</b> ) per admission
<b>Alternatives to hospital stays</b>		
<b>Outpatient surgery and physician surgical services</b>		
	\$100 then the plan pays 70% (of the balance of the <b>negotiated charge</b> ) per visit thereafter	50% (of the <b>recognized charge</b> ) per visit
<b>Home health care</b>		
Outpatient	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
Maximum visits per Calendar Year	120	120
<b>Hospice care</b>		
Inpatient facility	70% (of the <b>negotiated charge</b> ) per admission	50% (of the <b>recognized charge</b> ) per admission
Maximum days per lifetime	Unlimited	Unlimited
<b>Hospice care</b>		
Outpatient	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
<b>Outpatient private duty nursing</b>		
Outpatient private duty nursing	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
Maximum visits/shifts per Calendar Year	70 shifts  Up to eight hours equal one shift.	70 shifts  Up to eight hours equal one shift.

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<b>Skilled nursing facility</b>		
Inpatient facility	70% (of the <b>negotiated charge</b> ) per admission	50% (of the <b>recognized charge</b> ) per admission
Maximum days per Calendar Year	90	90
<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>
<b>Emergency services and urgent care</b>		
<b>Emergency services</b>		
Hospital emergency room	70% (of the <b>negotiated charge</b> ) per visit	Paid the same as in-network coverage
Non-emergency care in a <b>hospital</b> emergency room	Not covered	Not covered
<p><b>Important Note:</b>  As <b>out-of-network providers</b> do not have a contract with us the <b>provider</b> may not accept payment of your cost share, (<b>deductible, copayment, and payment percentage</b>, as payment in full. You may receive a bill for the difference between the amount billed by the <b>provider</b> and the amount paid by this plan. If the <b>provider</b> bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the <b>provider</b> over that amount. Make sure the member's ID number is on the bill.</p>		
<b>Urgent care</b>		
Urgent medical care (at a non- <b>hospital</b> free standing facility)	\$30 then the plan pays 100% (of the balance of the <b>negotiated charge</b> thereafter)  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit

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<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>
<b>Specific conditions</b>		
<b>Autism spectrum disorder</b>		
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other <b>illness</b> under this plan.		
<b>Birth center</b>		
Inpatient	\$200 then the plan pays 70% (of the balance of the <b>negotiated charge</b> ) per admission	\$400 then the plan pays 50% (of the balance of the <b>recognized charge</b> ) per admission
<b>Family planning services - other</b>		
<b>Voluntary sterilization for males</b>		
Outpatient	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
<b>Maternity and related newborn care</b>		
Inpatient	\$200 plus 70% (of the balance of the <b>negotiated charge</b> ) per admission	\$400 plus 50% (of the balance of the <b>recognized charge</b> ) per admission
<b>Delivery services and postpartum care services</b>		
Performed in a facility or at a <b>physician's</b> office	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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<b>Mental health treatment - inpatient</b>		
<p>Inpatient mental health treatment</p> <p>Inpatient <b>residential treatment facility</b></p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p>	<p>\$200 then the plan pays 70% (of the balance of the <b>negotiated charge</b>) per admission</p>	<p>\$400 then the plan pays 50% (of the balance of the <b>recognized charge</b>) per admission</p>
<b>Mental health treatment - outpatient</b>		
<p>Outpatient mental health treatment visits to a <b>physician or behavioral health provider</b> (includes skilled behavioral health services in the home)</p> <p><b>Partial hospitalization treatment</b> (at least 4 hours, but less than 24 hours per day of clinical treatment)</p> <p><b>Intensive Outpatient Program</b> (at least 2 hours per day and at least 6 hours per week of clinical treatment)</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p>	<p>\$50 then the plan pays 100% (of the balance of the <b>negotiated charge</b>) per visit thereafter</p> <p>No <b>deductible</b> applies</p>	<p>50% (of the <b>recognized charge</b>) per visit</p>
<p>Other outpatient mental health treatment</p>	<p>\$50 then the plan pays 100% (of the balance of the <b>negotiated charge</b>) per visit thereafter</p> <p>No <b>deductible</b> applies</p>	<p>50% (of the <b>recognized charge</b>) per visit</p>

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<b>Substance related disorders treatment - inpatient</b>		
<p>Inpatient <b>substance abuse</b> detoxification during a <b>hospital</b> confinement</p> <p>Inpatient <b>substance abuse</b> rehabilitation during a <b>hospital</b> confinement</p> <p>Inpatient <b>residential treatment facility</b> during a <b>hospital</b> confinement</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p>	<p>\$200 then the plan pays 70% (of the balance of the <b>negotiated charge</b>) per admission</p>	<p>\$400 then the plan pays 50% (of the balance of the <b>recognized charge</b>) per admission</p>
<b>Substance related disorders treatment - outpatient: detoxification and rehabilitation</b>		
<p>Outpatient <b>substance abuse</b> visits to a <b>physician</b> or <b>behavioral health provider</b></p> <p><b>Partial hospitalization treatment</b> (at least 4 hours, but less than 24 hours per day of clinical treatment)</p> <p><b>Intensive Outpatient Program</b> (at least 2 hours per day and at least 6 hours per week of clinical treatment)</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p>	<p>\$50 then the plan pays 100% (of the balance of the <b>negotiated charge</b>) per visit thereafter</p> <p>No <b>deductible</b> applies</p>	<p>50% (of the <b>recognized charge</b>) per visit</p>
<p>Other outpatient substance abuse services</p>	<p>\$50 then the plan pays 100% (of the balance of the <b>negotiated charge</b>) per visit thereafter</p> <p>No <b>deductible</b> applies</p>	<p>50% (of the <b>recognized charge</b>) per visit</p>

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<b>Oral and maxillofacial treatment (mouth, jaws and teeth)</b>		
Oral and maxillofacial treatment (mouth, jaws and teeth)	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
<b>Reconstructive breast surgery</b>		
Reconstructive breast surgery	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Reconstructive surgery and supplies</b>		
Reconstructive surgery	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

<b>Eligible health services</b>	<b>Network (IOE facility)</b>	<b>Network (Non-IOE facility)</b>	<b>Out-of-network coverage*</b>
<b>Transplant services facility and non-facility</b>			
Inpatient <b>hospital</b> transplant services	\$200 then the plan pays 70% (of the balance of the <b>negotiated charge</b> ) per transplant	\$400 then the plan pays 50% (of the balance of the <b>negotiated charge</b> ) per transplant	\$400 then the plan pays 50% (of the balance of the <b>recognized charge</b> ) per transplant
<b>Physician</b> services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Eligible health services</b>	<b>In-network coverage*</b>		<b>Out-of-network coverage*</b>
<b>Treatment of infertility</b>			
<b>Basic infertility</b>			
Basic <b>infertility</b>	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	

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Eligible health services	In-network coverage*	Out-of-network coverage*
<b>Specific therapies and tests</b>		
<b>Outpatient diagnostic testing</b>		
<b>Diagnostic complex imaging services</b>		
	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
<b>Diagnostic lab work</b>		
	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
<b>Diagnostic radiological services</b>		
	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
<b>Chemotherapy</b>		
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Outpatient infusion therapy</b>		
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Outpatient radiation therapy</b>		
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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<b>Short-term rehabilitation services</b>		
<b>Short-term rehabilitation services (outpatient physical therapies) combined with Habilitation therapy services (outpatient physical therapies)</b>		
	\$50 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Short-term rehabilitation services (outpatient occupational therapies) combined with Habilitation therapy services (outpatient occupational therapies)</b>		
	\$50 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Short-term rehabilitation services (outpatient speech therapies) combined with Habilitation therapy services (outpatient speech therapies)</b>		
	\$50 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Outpatient Physical Therapy Maximum</b>		
Maximum visits per Calendar Year	10 visits	10 visits
<b>Outpatient Occupational Therapy Maximum</b>		
Maximum visits per Calendar Year	10 visits	10 visits
<b>Outpatient Speech Therapy Maximum</b>		
Maximum visits per Calendar Year	10 visits	10 visits
<b>Spinal manipulation</b>		
Spinal manipulation	\$50 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
Maximum visits per Calendar Year	10 visits	10 visits

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

<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>
<b>Other services</b>		
<b>Acupuncture</b>		
Acupuncture	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

<b>Ambulance service</b>		
Ground, air or water ambulance	70% (of the <b>negotiated charge</b> ) per trip	50% (of the <b>recognized charge</b> ) per trip

<b>Clinical trial therapies (experimental or investigational)</b>		
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

<b>Clinical trials (routine patient costs)</b>		
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

<b>Durable medical equipment (DME)</b>		
DME	70% (of the <b>negotiated charge</b> ) per item	50% (of the <b>recognized charge</b> ) per item

<b>Prosthetic devices</b>		
Prosthetic devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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

<b>Eligible health services</b>	
<b>Family planning services - female contraceptives</b>	
Female contraceptives that are <b>generic prescription drugs</b> :  <ul style="list-style-type: none"> <li>• Oral drugs</li> <li>• Injectable drugs</li> <li>• Vaginal rings</li> <li>• Transdermal contraceptive patches</li> </ul>	100% per <b>prescription</b> or refill  No <b>deductible</b> applies
Female contraceptives that are <b>brand-name prescription drugs</b> :  <ul style="list-style-type: none"> <li>• Oral drugs</li> <li>• Injectable drugs</li> <li>• Vaginal rings</li> <li>• Transdermal contraceptive patches</li> </ul>	100% per <b>prescription</b> or refill  No <b>deductible</b> applies
Female contraceptive generic devices and brand-name devices	100% per <b>prescription</b> or refill  No <b>deductible</b> applies
<b>Preventive care drugs and supplements</b>	
Preventive care drugs and supplements filled at a <b>pharmacy</b>	100% per <b>prescription</b> or refill  No <b>deductible</b> applies

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

<b>Risk reducing breast cancer prescription drugs</b>	
Risk reducing breast cancer <b>prescription drugs</b> filled at a <b>pharmacy</b>	100% per <b>prescription</b> or refill  No <b>deductible</b> applies
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.
<b>Tobacco cessation prescription and over-the-counter drugs</b>	
Tobacco cessation <b>prescription drugs</b> and OTC drugs filled at a <b>pharmacy</b> for each 90 day supply	\$0 per <b>prescription</b> or refill  No <b>deductible</b> applies
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below.  Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation <b>prescription drugs</b> and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.

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

## General coverage provisions

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This section provides detailed explanations about the:

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

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

### Deductible provisions

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

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

### Individual

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

### Family

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

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

- The combined **eligible health services** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

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

## Per Admission Deductible

A per admission **deductible** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility.

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

**Eligible health services** applied to the per admission **deductible** cannot be applied to any other **deductible** required in this plan. Likewise, **eligible health services** applied to this plan's other **deductibles** cannot be applied to meet the per admission **deductible**.

## Copayments

### Copayment

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

## Payment percentage

The specific percentage you have to pay for a health care service listed in the schedule of benefits.

## Maximum out-of-pocket limits provisions

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

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

### Individual

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

### Family

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

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

To satisfy this family **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 **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a Calendar Year.

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

#### Costs that you incur that do not apply to your **maximum out-of-pocket limit**

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

- All costs for non-covered services
- All costs for non-emergency use of the emergency room
- Any out of pocket costs for outpatient **prescription drugs**
- As it applies to out-of-network coverage: Charges, expenses or costs in excess of the **recognized charge**

#### **Maximum provisions**

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

#### **Calculations; determination of recognized charge; determination of benefits provisions**

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

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