

Schedule of Benefits

Employer: **Omaha Track, Inc.**
 MSA: 450352
 Issue Date: May 23, 2016
 Effective Date: February 1, 2016
 Schedule: 1A
 Booklet Base: 1

For: Choice POS II - High Deductible Health Plan

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	\$3,500	\$7,000
Family Deductible*	\$7,000	\$14,000

*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: \$6,500.
- For **out-of-network** expenses: \$13,000.

Family Maximum Out of Pocket Limit:

- For **network** expenses: \$13,000.
- For **out-of-network** expenses: \$26,000.

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.	70% 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 American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. <i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. <i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>
<i>Covered Persons ages 22 but less than 65: Maximum Visits per 12 consecutive month period</i>	1 visit	1 visit
<i>Covered Persons age 65 and over: Maximum Visits per 12 consecutive month period</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. Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. <i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>	70% per visit after Calendar Year deductible Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. <i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>

Screening & Counseling Services	100% per visit No copay or deductible applies.	70% per visits after Calendar Year deductible
Office Visits		
Obesity and/or Healthy Diet		
Misuse of Alcohol and/or Drugs & Use of Tobacco Products		
Sexually Transmitted Infections		
Genetic Risk for Breast and Ovarian Cancer		

<i>Obesity and/or Healthy Diet</i>		
Maximum Visits per 12 consecutive month period <i>(This maximum applies only to Covered Persons ages 22 & older.)</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>	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.		

<i>Misuse of Alcohol and/or Drugs</i>		
Maximum Visits per 12 consecutive month period	5 visits*	5 visits*
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		

<i>Use of Tobacco Products</i>		
Maximum Visits per 12 consecutive month period	8 visits*	8 visits*
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		

<i>Sexually Transmitted Infections Benefit Maximums</i>		
Maximum Visits per Calendar Year	2 visits*	2 visits*
*Note: In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.		

Well Woman Preventive Visits Office Visits	100% per visit	70% per visit after Calendar Year deductible
Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations	No Calendar Year deductible applies.	
Well Woman Preventive Visits		
Maximum Visits per Calendar Year	1 visit	1 visit
Routine Cancer Screening Outpatient	100% per visit	70% per visit after Calendar Year deductible
	No Calendar Year deductible applies.	
Maximums	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and the comprehensive guidelines supported by the Health Resources and Services Administration. <p><i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i></p>	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and the comprehensive guidelines supported by the Health Resources and Services Administration. <p><i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i></p>
<i>Lung Cancer Screening Maximum</i>	One screening every 12 months*	One screening every 12 months*
*Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.		
Prenatal Care Office Visits	100% per visit	70% per visit after Calendar Year deductible
	No copay or deductible applies.	
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 <i>Facility or Office Visits</i>	100% per visit No copay or deductible applies.	70% 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	70% 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 Services - Female Contraceptives		
Female Contraceptive Generic Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visits.	100% per item. No copay or deductible applies.	50% per item after Calendar Year deductible
Family Planning - Other		
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
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	80% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible
Physician Office Visits-Surgery	80% per visit after Calendar Year deductible	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.	70% per visit after Calendar Year deductible
Individual Screening and Counseling Services for Tobacco Use	100% per visit No copay or deductible applies.	70% per visit after Calendar Year deductible
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
Individual Screening and Counseling Services for Obesity	100% per visit No copay or deductible applies.	70% per visit after Calendar Year deductible
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
*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	80% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible
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Administration of Anesthesia	80% per procedure after Calendar Year deductible	50% per procedure after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Emergency Medical Services		
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Hospital Emergency Facility and Physician	80% per visit after the Calendar Year deductible	Paid the same as the Network level of benefits.
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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
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Urgent Care Services		
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Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	100% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
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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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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Outpatient Diagnostic and Preoperative Testing		
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Complex Imaging Services		
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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

Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	80% per procedure after Calendar Year deductible	50% per procedure after Calendar Year deductible

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birth 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
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Maximum Days per Calendar Year	60 days	60 days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
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	60 visits	60 visits
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Skilled Nursing Care (Outpatient)	80% per visit after the Calendar Year deductible	50% per visit after the Calendar Year deductible
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Private Duty Nursing (Outpatient)	80% per visit after the Calendar Year deductible	50% per visit after the Calendar Year deductible
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Maximum Visit Limit per <i>Calendar Year</i>	60 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	60 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.
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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	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible

Maximum Benefit per lifetime	Unlimited days	Unlimited days
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Hospice Outpatient Visits	80% 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

<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% after Calendar Year deductible	50% after Calendar Year deductible

Outpatient Treatment Of Mental Disorders

<i>Outpatient Services</i>	80% per visit after the Calendar Year deductible	50% per visit after the Calendar Year deductible
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PLAN FEATURES NETWORK OUT-OF-NETWORK

Inpatient Treatment of Substance Abuse

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

<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

Outpatient Treatment of Substance Abuse

<i>Outpatient Treatment</i>	80% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible
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PLAN FEATURES NETWORK (IOE Facility) NETWORK (Non-IOE Facility) OUT-OF-NETWORK

Transplant Services Facility and Non-Facility Expenses

<i>Transplant Facility Expenses</i>	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible
<i>Transplant Physician Services</i> (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
Clinical Trial Therapies (Experimental or Investigational Treatment)	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.
Routine Patient Costs	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.
Jaw Joint Disorder Treatment	80% per visit after Calendar Year deductible	50% per visit after 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		
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.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorder		
Autism – Physical Therapy, Occupational Therapy, Speech Therapy	80% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible
Autism - Behavioral Therapy	80% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible
Autism - Applied Behavior Analysis	80% per visit after Calendar Year deductible	50% per visit 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

Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year	60 visits	60 visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	80% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible

Spinal Manipulation Maximum visits per Calendar Year	20 visits	20 visits
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Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Generic and Brand-Name Prescription Drugs		
For each initial 30 day supply filled at a retail pharmacy	None	None
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy	None	Not Applicable

If a **prescriber** prescribes a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost sharing for the **brand-name prescription drug**. If you request a covered brand-name **prescription drug** where a **generic prescription drug** equivalent is available you will be responsible for the cost difference between the **brand-name prescription drug** and the **generic prescription drug** equivalent, plus the applicable cost sharing.

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to risk-reducing breast cancer generic **prescription drugs** when obtained at a **network pharmacy**. This means that such risk-reducing breast cancer generic **prescription drugs** will be paid at 100%.

Deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs

The **prescription drug deductible** and the per **prescription copayment/coinsurance** will not apply to the first two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%. Your **prescription drug deductible** and any **prescription copayment/coinsurance** will apply after those two regimens have been exhausted.

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; or
- FDA-approved female generic emergency contraceptives,

when obtained at a **network pharmacy**. This means that such contraceptive methods will be paid at 100%.

Refer to the *Pharmacy Plan Features* for information on coverage for FDA-Approved female over-the-counter contraceptives (Non-Emergency).

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** continue to apply:

- When the contraceptive methods listed above are obtained at an out-of-network pharmacy

- For contraceptive methods that are:
 - **brand-name prescription drugs** and devices and
 - FDA-approved female brand-name emergency contraceptives,

that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** obtained at an **out-of-network pharmacy** or **network pharmacy** unless you are granted a medical exception.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
FDA-Approved Female Generic Over-the-Counter Contraceptives For each 30 day supply filled at a retail pharmacy	100% per supply No copay or deductible applies.	Not covered.
FDA-Approved Female Generic Emergency Over-the-Counter Contraceptives	100% per supply No copay or deductible applies.	Not covered.

Important Note:

This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact Member Services by logging on the Aetna website at www.aetna.com or calling the toll-free number on the back of the ID card.

Preventive Care Drugs and Supplements

Preventive care drugs and supplements filled at a pharmacy with a prescription :	100% per item. No copay or deductible applies.	Not Covered.
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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 your physician or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.

Important Note:

Refer to the **Booklet** and the **Preventive Care** section for a complete description of the preventive care drugs and supplements covered under this Plan and for any limitations that apply to these benefits.

Tobacco Cessation Prescription and Over-the-Counter Drugs

Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply. 100% per supply Not covered.
 No **copay** or **deductible** 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 prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the negotiated charge	80% of the recognized charge

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.

Precertification and **step therapy** for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

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*.

Covered expenses that are subject to the **deductibles** include covered expenses provided under the Medical or **Prescription drug** Plans, as applicable.

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.

Covered expenses that are subject to the **Maximum Out-of-Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

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;
- Expenses for non-emergency use of the emergency room;
- 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.