

Schedule of Benefits

Employer: State of Maine
 ASAMSA: 307297
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 Schedule: 2A
 Booklet Base: 2

For: Aetna Choice POS II Plan (Out-of-State Plan)

Aetna Choice POS II Medical Plan

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

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

Plan Maximum Out of Pocket Limit includes plan **deductible** and in-network medical copays.

Plan Maximum Out of Pocket Limit excludes **precertification** penalties of \$500 per type of covered expenses.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: \$2,000.
- For **out-of-network** expenses: \$2,000.

Family Maximum Out of Pocket Limit:

- For **network** expenses: \$4,000.
- For **out-of-network** expenses: \$4,000.

Prescription Drug Maximum Out-of-Pocket Limit

| | NETWORK | OUT-OF-NETWORK |
|---|--------------------------------------|----------------|
| Prescription Drug Maximum Out-of-Pocket Limit does not apply to out of network | \$4,600 Individual \$9,200 Family | Does not apply |
| Lifetime Maximum Benefit per person | Unlimited | Unlimited |

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

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

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

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| Preventive Care Benefits | | |
| Routine Physical Exams Office Visits | 100% per visit No copay or Calendar Year deductible applies. | 80% per visit after Calendar Year deductible |
| <i>Covered Persons birth through age 18: Maximum Age & Visit Limits</i> | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. |
| <i>Covered Persons ages 18 and over Maximum Visits per 12 months</i> | 1 visit | 1 visit |
| Preventive Care Immunizations | | |
| <i>Performed in a facility or physician's office</i> | 100% per visit No copay or Calendar Year 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 custom website www.aetnastateofmaine.com or calling the number on the back of your ID card.</i> | Not Covered |

Screening & Counseling Services

| | | |
|---|---|---|
| Screening & Counseling Services | 100% per visits | 80% per visits after Calendar Year deductible |
| Office Visits Obesity and/or Healthy Diet | No copay or Calendar Year deductible applies. | |
| Misuse of Alcohol and/or Drugs & Use of Tobacco Products | | |
| Sexually Transmitted Infections | | |
| Genetic Risk for Breast and Ovarian Cancer | | |

Obesity

| | | |
|---|---|---|
| Maximum Visits per 12 months (This maximum applies only to Covered Persons ages 22 & older.) | 26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* | 26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* |
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In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

Misuse of Alcohol and/or Drugs

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|------------------------------|-----------|-----------|
| Maximum Visits per 12 months | 5 visits* | 5 visits* |
|------------------------------|-----------|-----------|

***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

PLAN FEATURES

NETWORK

OUT-OF-NETWORK

Use of Tobacco Products

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| Maximum Visits per 12 months | 8 visits* | 8 visits* |
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In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

Well Woman Preventive Care

Well Woman Preventive Visits

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| Office Visits | 100% per visit | 80% 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

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| Maximum Visits per Calendar Year | 1 visit | 1 visit |
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Hearing Care

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| 36 month period for children under age 19 | deductible up to \$1,400 per ear | deductible up to \$1,400 per ear |
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| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
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| <i>Routine Cancer Screenings</i> | | |
| <i>Routine Cancer Screening Outpatient</i> | 100% per visit deductible applies. | 80% per visit Calendar Year deductible applies. |

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| Maximums | Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. <i>physician, log onto the custom website www.aetnastateofmaine.com, or call the number on the back of your ID card.</i> | Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. <i>physician, log onto the custom website www.aetnastateofmaine.com, or call the number on the back of your ID card.</i> |
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| <i>Lung Cancer Screening Age 55 and above</i> | 100% per test No Calendar Year deductible applies. | Not Covered |
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| <i>Lung Cancer Screening Maximum</i> | One screening every 12 months* | Not Covered |
|---|--------------------------------|-------------|

***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.**

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| <i>Prenatal Care</i> | | |
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| <i>Prenatal Care Office Visits</i> | 100% per visit No copay or Calendar Year deductible applies. | 60% per visit after Calendar Year deductible . |
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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.

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
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| <i>Lactation Support and Counseling Services</i> | | |
| <i>Comprehensive Lactation Support and Counseling Services Lactation Counseling Services Facility or Office Visits</i> | 100% per visit No copay or deductible applies. | 60% per visit after Calendar Year deductible |

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| Lactation Counseling Services Maximum Visits either in a group or individual setting | 6* visits per 12 months | 12 months |
| *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> . | | |

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| Breast Pumps & Supplies | 100% per item. No copay or Calendar Year deductible applies. | 60% 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. | | |

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

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| Contraceptive Counseling Services - Maximum Visits either in a group or individual setting | 2* visits per 12 months | 2* visits per 12 months |
| *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> . | | |

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| Family Planning - Other | | |
| Voluntary Termination of Pregnancy Outpatient and office | 80% per visit after Calendar Year deductible. | 60% per visit after Calendar Year deductible. |
| Voluntary Sterilization for Males Outpatient and office | 80% per visit after Calendar Year deductible. | 60% per visit after Calendar Year deductible. |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| Family Planning - Female Voluntary Sterilization | | |
| Inpatient | 100% per visit No Calendar Year deductible applies | 60% per visit after Calendar Year deductible |
| Outpatient and office | per visit after Calendar Year deductible No . | 60% per visit after Calendar Year deductible |
| Voluntary Sterilization for Males | | |
| InpatientInpatient | 100% per visit No Calendar Year deductible applies. | 60% per visit after Calendar Year deductible |

Family Planning Services - Female Contraceptives

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| 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. | 60% per item after Calendar Year deductible |
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Family Planning - Female Contraceptives

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| Female Contraceptives | 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 |
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| Vision Care | | |
| Eye Examinations including refraction | 100% per exam No Calendar Year deductible applies. | 60% per exam after Calendar Year deductible |
| Maximum Benefit per Calendar Year | 1 exam | 1 exam |

| 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 | 60% per visit after Calendar Year deductible |
| Alternatives to Physicians' Office Visit | | |
| E-Visit Online or Telephonic Consultation by a PCP | 80% per visit after Calendar Year deductible | Not Covered |
| Specialist Office Visits | 80% per visit after Calendar Year deductible | 60% per visit after Calendar Year deductible |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|--|---|---|
| Alternative to Specialist Office Visit | | |
| E-visits Online Internet Consultation by a Specialist | 80% per visit after Calendar Year deductible | Not Covered |
| Physician Office Visits-Surgery | 80% per visit after Calendar Year deductible | 60% per visit after Calendar Year deductible |

Walk-In Clinic Visit (Non-Emergency)

Preventive Care Services*

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|---------------|---|---|
| Immunizations | 80% per visit after Calendar Year deductible | 60% per visit after Calendar Year deductible |
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For details, contact your **physician**, log onto the *custom website www.aetnastateofmaine.com*, or call the number on the back of your ID card.

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| Individual Screening and Counseling Services for Tobacco Use | 80% per visit after Calendar Year deductible | 60% per visit after Calendar Year deductible |
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| Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use | Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services | Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services |
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| Individual Screening and Counseling Services for Obesity | 80% per visit after Calendar Year deductible | 60% per visit after Calendar Year deductible |
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|--|---|---|
| Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity | Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services | Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services |
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***Important Note:**

Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.

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| <i>All Other Services</i> | 80% per visit after Calendar Year deductible | 60% per visit after Calendar Year deductible |
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| <i>Physician Services for Inpatient Facility and Hospital Visits</i> | 100% per visit | 80% per visit after Calendar Year deductible |
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No Calendar Year **deductible** applies.

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| <i>Administration of Anesthesia</i> (may be billed separately) | 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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| <i>Allergy Testing and Treatment</i> | 80% per visit after applicable copay | 60% per visit after Calendar Year deductible |
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No Calendar Year **deductible** applies

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| Allergy Injections | 80% per visit after Calendar Year deductible | 60% per visit after Calendar Year deductible |
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| Immunizations (when not part of the physical exam) | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. Not Covered |
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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 | \$300 copay per visit then the plan pays 100% | \$ 300 copay then the plan pays 100% |
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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.

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| Non-Emergency Care in a Hospital Emergency Room | \$300 copay per visit then the plan pays 100% | \$300 copay per visit then the plan pays 100% |
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Important Notice:

A separate **hospital** emergency room **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived.

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---------------|---------|----------------|
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| Urgent Care Services | | |
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| Urgent Medical Care (at a non-hospital free standing facility) | \$75 per visit copay then the plan pays 100% | 60% per visit after Calendar Year deductible |
| | No Calendar Year deductible applies. | No Calendar Year deductible applies. |

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| Urgent Medical Care (from other than a non-hospital free standing facility) | 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> | \$75 per visit copay then the plan pays 100% | 60% per visit after Calendar Year deductible |
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Important Notice:
A separate **urgent care copay** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care copay/deductible** cannot be applied to any other **copay/deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay/deductible**.

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---------|----------------|
| Outpatient Diagnostic and Preoperative Testing | | |

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| Complex Imaging Services | | |
| Complex Imaging (MRI, Cat Scan, Pet Scan) | 80% per test after Calendar Year deductible | 60% per test after Calendar Year deductible |

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| Diagnostic Laboratory Testing | | |
| Diagnostic Laboratory Testing | 80% per procedure after Calendar Year deductible | 60% per procedure after Calendar Year deductible |

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| Diagnostic X-Rays (except Complex Imaging Services) | | |
| Diagnostic X-Rays (including ultrasounds) | 80% per procedure after Calendar Year deductible | 60% per procedure after Calendar Year deductible |
| <i>Allows 2 diagnostic Mammograms per Calendar Year</i> | 100% per test No Calendar Year deductible applies | 80% per test after Calendar Year deductible . |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---------------------------|--|--|
| Outpatient Surgery | | |
| Outpatient Surgery | 80% per visit/surgical procedure No Calendar Year deductible applies | 60% per visit/surgical procedure after Calendar Year deductible |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|--|--|--|
| <i>Inpatient Facility Expenses</i> | | |
| <i>Birthing Center</i> | 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. |
| <i>Hospital Facility Expenses</i> | 100% per admission after Calendar Year deductible | 80% per admission after Calendar Year deductible |
| Room and Board (including maternity) | | |
| Other than Room and Board | 100% per admission after Calendar Year deductible | 80% per admission after Calendar Year deductible |
| <i>Skilled Nursing Inpatient Facility</i> | 80% per admission after Calendar Year deductible | 60% per admission after Calendar Year deductible |
| Maximum Days per Calendar Year | 100 days | 100 days |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| <i>Specialty Benefits</i> | | |
| <i>Home Health Care (Outpatient)</i> | 80% per visit after the Calendar Year deductible | 60% per visit after the Calendar Year deductible |
| <i>Hospice Benefits</i> | | |
| <i>Hospice Care - Facility Expenses (Room & Board)</i> | 80% per admission after Calendar Year deductible | 60% per admission after Calendar Year deductible |
| <i>Hospice Care - Other Expenses during a stay</i> | 80% per admission after Calendar Year deductible | 60% per admission after Calendar Year deductible |
| Maximum Benefit per lifetime | Unlimited days | Unlimited days |

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| <i>Hospice Outpatient Visits</i> | 80% per visit after Calendar Year deductible | 60% per visit after Calendar Year deductible |
|---|---|---|

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|--|--|
| <i>Infertility Treatment</i> | | |
| <i>Basic Infertility Expenses</i> | 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. |
| Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only. | | |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|--|--|---|
| <i>Inpatient Treatment of Mental Disorders</i> | | |
| <i>Hospital Facility Expenses</i> | | |
| Room and Board | 100% per admission after Calendar Year deductible | 60% per admission after Calendar Year deductible |
| Other than Room and Board | 100% per admission after Calendar Year deductible | 60% per admission after Calendar Year deductible |
| Physician Services | 100% per admission after Calendar Year deductible | 60% per admission after Calendar Year deductible |
| <i>Inpatient Residential Treatment Facility Expenses</i> | 100% per admission after Calendar Year deductible | 60% per admission after Calendar Year deductible |
| <i>Inpatient Residential Treatment Facility Expenses Physician Services</i> | 100% after Calendar Year deductible | 60% after Calendar Year deductible |
| <i>Outpatient Treatment Of Mental Disorders</i> | | |
| <i>Outpatient Services</i> | 80% per visit after the Calendar Year deductible | 60% per visit after the Calendar Year deductible |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|--|--|---|
| <i>Inpatient Treatment of Substance Abuse</i> | | |
| <i>Hospital Facility Expenses</i> | | |
| Room and Board | 100% per admission after Calendar Year deductible | 60% per admission after Calendar Year deductible |
| Other than Room and Board | 100% per admission after Calendar Year deductible | 60% per admission after Calendar Year deductible |
| Physician Services | 100% per admission after Calendar Year deductible | 60% per admission after Calendar Year deductible |
| <i>Inpatient Residential Treatment Facility Expenses</i> | 100% per admission after Calendar Year deductible | 60% per admission after Calendar Year deductible |
| <i>Inpatient Residential Treatment Facility Expenses Physician Services</i> | 100% per visit after Calendar Year deductible | 60% per visit after Calendar Year deductible |

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

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|--|--|--|
| Obesity Treatment Non Surgical | | |
| Outpatient Obesity Treatment (non surgical) | 80% per visit after the Calendar Year deductible | 60% 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) | 80% per admission after Calendar Year deductible | 60% per admission after Calendar Year deductible |

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|--|--|--|
| Outpatient Morbid Obesity Surgery | 80% per service after Calendar Year deductible | 60% per service after Calendar Year deductible |
|--|--|--|

| PLAN FEATURES | NETWORK (IOE Facility) | NETWORK (Non-IOE Facility) | OUT-OF-NETWORK |
|--|--|--|--|
| Transplant Services Facility and Non-Facility Expenses | | | |
| Transplant Facility Expenses | 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. |
| Transplant Physician Services (including office visits) | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|--|--|--|
| Other Covered Health Expenses | | |
| Acupuncture in lieu of anesthesia | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |

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|---------------------------------------|------------------------------------|------------------------------------|
| Ground, Air or Water Ambulance | 80% after Calendar Year deductible | 60% after Calendar Year deductible |
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| <i>Diabetic Equipment, Supplies and Education</i> | 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. |
| <i>Durable Medical and Surgical Equipment</i> | 80% per item after Calendar Year deductible | 60% per item after the Calendar Year deductible |
| <i>Clinical Trial Therapies</i> (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. |
| <i>Routine Patient Costs</i> | 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. |
| <i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i> | 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. |
| <i>Prosthetic Devices</i> | Payable in accordance 80% per item after Calendar Year deductible | Payable in accordance with the type of expense incurred and the place where service is provided. 60% per item after Calendar Year deductible |
| <i>Limb Replacement</i> | 80% per item No Calendar Year deductible applies | 60% per item after Calendar Year deductible |
| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
| <i>Outpatient Therapies</i> | | |
| <i>Chemotherapy</i> | 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. |
| <i>Infusion Therapy</i> | 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. |
| <i>Radiation Therapy</i> | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|--|--|--|
| Short Term Outpatient Rehabilitation Therapies | | |
| <i>Outpatient Physical and Occupational Therapy only</i> | 80% per visit after Calendar Year deductible | 60% per visit after Calendar Year deductible |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|--|--|
| Short Term Outpatient Rehabilitation Therapies | | |
| <i>Speech Therapy only</i> | 80% per visit after Calendar Year deductible | 60% per visit after Calendar Year deductible |

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

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|-----------|----------------|
| Spinal Manipulation Maximum visits | | |
| Maximum Visits per Calendar Year | 25 visits | 25 visits |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---------------------------------|---|---|
| Autism Spectrum Disorder | | |
| | Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.. | Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.. |

Pharmacy Benefit

Copays/Deductibles

| PER PRESCRIPTION COPAY/DEDUCTIBLE | NETWORK | OUT-OF-NETWORK |
|--|---------|----------------|
| Preferred Generic Prescription Drugs | | |
| For each initial 90 day supply filled at a retail pharmacy | \$10 | \$10 |
| For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy | \$15 | Not Applicable |

Preferred Brand-Name Prescription Drugs

| | | |
|---------------------------------|------|----------------|
| For each 90 day supply (retail) | \$30 | \$30 |
| 91 day supply (mail order) | \$45 | Not Applicable |

Non-Preferred Generic Prescription Drugs

| | | |
|---------------------------------|------|----------------|
| For each 90 day supply (retail) | \$10 | \$10 |
| 91 day supply (mail order) | \$15 | Not Applicable |

Non-Preferred Brand-Name Prescription Drugs

| | | |
|--|------|----------------|
| For each initial 90 day supply filled at a retail pharmacy | \$45 | \$45 |
| For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy | \$70 | Not Applicable |

Diabetic prescription drugs, supplies and insulin

| | | |
|--|-----|-----|
| For each 30 day supply filled at a retail pharmacy (For members in the TDES Program) | \$0 | \$0 |
|--|-----|-----|

Infertility/ Erectile Dysfunction Prescription Drugs

| | | |
|--|------|----------------|
| For each 30 day supply (retail) | \$50 | \$50 |
| For more than a 30 day supply but less than a 91 day supply (mail order) | \$75 | 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 certain 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 *custom website* www.aetnastateofmaine.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. |
|--|---|--------------|

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 *custom website www.aetnastateofmaine.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.

Coinsurance

| | NETWORK | OUT-OF-NETWORK |
|---|--------------------------------------|--------------------------------------|
| Prescription Drug Plan Coinsurance | 100% of the negotiated charge | 100% 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.

Prescription Drug Maximum Out-of-Pocket Limit

| | NETWORK | OUT-OF-NETWORK |
|---|--------------------------------------|-----------------------|
| Prescription Drug Maximum Out-of-Pocket Limit does not apply to out of network | \$4,600 Individual \$9,200 Family | Does not apply |

Individual Prescription Drug Maximum Out-of-Pocket Limit: Your plan has limitations set for what you are expected to contribute. Your plan will pay benefits for **prescription drug covered expenses**, as follows:

Prescription Drug Maximum Out-of-Pocket Limit

When your share or each of your covered dependent’s share of **prescription drug covered expenses** reach the **prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of that person’s **prescription drug covered expenses** for the rest of the calendar year. The **prescription drug Maximum Out-of-Pocket Limit** applies to **network** and **out-of-network prescription drug covered expenses** combined.

Family Prescription Drug Maximum Out-of-Pocket Limit. Your plan has limitations set for what your family is expected to contribute. Your plan will pay benefits for **covered expenses** as follows:

Prescription Drug Maximum Out-of-Pocket Limit

When your share and your covered dependents share of **prescription drug covered expenses** combined reach the family **prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of the family’s **covered expenses** for the rest of the calendar year. The family **prescription drug Maximum Out-of-Pocket Limit** applies to **network** and **out-of-network prescription drug covered expenses** combined.

Excluded Covered Expenses

Certain **prescription drug covered expenses** do not apply toward your individual **prescription drug** payment percentage limit and the family prescription **drug** payment percentage limit. These include:

Expenses applied toward a deductible or copay amount.

Expenses above the **recognized charge**.

Non-covered **expenses**.

Expense Provisions

The following provisions apply to your health expense plan.

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

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

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

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

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

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Network Provider Calendar Year Deductible

Individual

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** for the rest of the Calendar Year.

Family Deductible Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

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

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

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

Out-of-Network Provider Calendar Year Deductible

Individual

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

Family Deductible Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

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

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

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

Deductible Carryover

Under this feature, any **covered expenses** that you incur in the last three months of a Calendar Year that apply toward that year's Calendar Year **deductibles** for **network providers** or **out-of-network** providers will also count toward the following year's **network providers** or **out-of-network** providers **deductibles**.

Deductible Waiver Provision for Preventive Prescription Drug Expenses

No **deductible** will apply to preventive covered **prescription drug** expenses for those **prescription drugs** used to treat the prevention of conditions relating to:

- Hypertension;
- Heart disease;
- Diabetic complications;
- Asthmatic episodes;
- Conditions resulting from osteoporosis;
- Stroke;
- Various pediatric conditions, such as vitamins and fluoride deficiency, and maternal and fetal problems during pregnancy

The preventive **prescription drug** list is available from your employer in printed form. Member Services can answer any questions you have about this preventive **prescription drug** list.

Copayments and Benefit Deductible Provisions

Copayment, Copay

This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Payment Provisions

Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Payment Percentage”. Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Maximum Out-of-Pocket Limit

The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual **Maximum Out-of-Pocket Limit**. As to the individual **Maximum Out-of-Pocket Limit**, each of you must meet your **Maximum Out-of-Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out-of-Pocket Limit**. See list below.

Network Provider Maximum Out-of-Pocket Limit

Individual

Once the amount of eligible **network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out-of-Pocket Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

Out-of-Network Provider Maximum Out-of-Pocket Limit

Individual

Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out-of-Pocket Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **out-of-network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **out-of-network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **out-of-network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **out-of-network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **out-of-network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

The **Maximum Out-of-Pocket Limit** applies to both network and out-of-network benefits. **Covered expenses** applied to the out-of-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the in-network **Maximum Out-of-Pocket Limit** and **covered expenses** applied to the in-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the out-of-network **Maximum Out-of-Pocket Limit**.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge** for **out-of-network providers** only;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- 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** for out-of-network providers when required will result in a benefits reduction as follows:

- A \$500 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.