

# Schedule of Benefits

Employer: State of Maine  
 ASA: 307297  
 Issue Date: May 25, 2012  
 Effective Date: July 1, 2012  
 Schedule: 1A  
 Booklet Base: 1

For: Aetna Choice POS II Plan (In State Plan)

## Gatekeeper PPO Medical Plan

PLAN FEATURES	NETWORK-Preferred	NETWORK-Referred	NETWORK Self-Referred	OUT-OF-NETWORK
<b>Calendar Year Deductible*</b>				
Individual Deductible*	\$300	\$1,500	\$2,500	\$2,500
Family Deductible*	\$600	\$3,000	\$5,000	\$5,000

\*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 of \$500 per type of covered expense.

PLAN MAXIMUM	NETWORK-Preferred	NETWORK-Referred	NETWORK - Self -Referred	OUT-OF-NETWORK
Individual Maximum Out of Pocket Limit	\$1,100	\$3,000	\$5,000	\$5,000
Family Maximum Out of Pocket Limit	\$2,200	\$6,000	\$10,000	\$10,000

<i>Lifetime Maximum Benefit per person</i>	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
<b>Preventive Care Benefits</b>		
<b>Routine Physical Exams</b> Includes coverage for immunizations.	100% per visit  No copay or deductible applies.	No Coverage
<i>Covered Persons birth through age 18</i> Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.  <i>For details, contact your <b>physician</b> log onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of your ID card.</i>	No Coverage.
<i>Covered Persons ages 18 and over.</i> Maximum Visits per Calendar Year	1 visit	No Coverage
<b>Screening &amp; Counseling Services - Obesity, Misuse of Alcohol and/or Drugs &amp; Use of Tobacco Products</b>	100% per visit  No copay or deductible applies.	No Coverage
<i>Obesity</i> Maximum Visits per Calendar Year <i>(This maximum applies only to Covered Persons ages 22 &amp; 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>	No coverage
<b>*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</b>		
<i>Misuse of Alcohol and/or Drugs</i> Maximum Visits per Calendar Year	5 visits *	No Coverage
<b>*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</b>		
<i>Use of Tobacco Products</i> Maximum Visits per Calendar Year	8 visits *	No Coverage

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

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Hearing Exam</b>		
<i>Preferred Network Provider</i>	\$25 exam <b>copay</b> then the plan pay 100%	60% per exam after Calendar Year <b>deductible</b>
<i>Referred Network Provider</i>	\$25 exam <b>copay</b> then the plan pay 100%	60% per exam after Calendar Year <b>deductible</b>
<i>Self Referred Network Provider</i>	60% per exam after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per exam after Calendar Year <b>deductible</b>

Hearing Supply Maximum per 36 month period children to age 19		
<i>Preferred Network Provider</i>	100% per exam after <b>preferred deductible</b>	60% per exam after Calendar Year <b>deductible</b>
<i>Referred Network Provider</i>	100% per exam after <b>preferred deductible</b>	60% per exam after Calendar Year <b>deductible</b>
<i>Self- Referred Network Provider</i>	60% per exam after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per exam after Calendar Year <b>deductible</b>
Maximum Benefit per ear	\$1,400	\$1,400

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Routine Cancer Screenings</b>		
<i>Routine Gynecological Exam (Including Routine Pap Smears)</i>	100% per exam No Calendar Year <b>deductible</b> applies.	100% per exam No Calendar Year <b>deductible</b> applies

Maximum exams per Calendar Year	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.  <i>For details, contact your <b>physician</b>, log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.  <i>For details, contact your <b>physician</b>, log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of your ID card.</i>
---------------------------------	---	---

<b>All Other Routine Exams and Screenings</b>	100% per exam No Calendar Year <b>deductible</b> applies.	No Coverage
---	---	-------------

Maximum tests per Calendar Year	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.  <i>For details, contact your <b>physician</b>, [log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>,] or call the number on the back of your ID card.]</i>	No Coverage
---------------------------------	--	-------------

<b>Family Planning Services</b>		
<i>Family Planning Services</i>		
<b>In office Preferred Network Provider</b>	100% per visit No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>
<b>In office Referred Network Provider</b>	100% per visit after <b>referred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<b>In Office Self-Referred Network</b>	60% after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<b>Other place of service Preferred Network Provider</b>	95% per visit after <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<b>Other place of service Referred Network Provider</b>	80% per visit after <b>referred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<b>Other place of service Self-Referred Network</b>	60% per visit after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Vision Care</i></b>		
<b><i>Eye Examinations</i></b> including refraction	100% per exam No Calendar Year <b>deductible</b> applies.	100% per exam  No Calendar Year <b>deductible</b> applies
Maximum Benefit per Calendar Year to age 19	1 exam	1 exam
Maximum Benefit every 2 calendar years age 19 to 65	1 exam	1 exam
Maximum Benefit per Calendar Year age 65 and over	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Physician Services</i></b>		
<b><i>Physician Office Visits</i></b>		
<b><i>Preferred Network</i></b>	100% per visit No Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>
<b><i>Referred Network</i></b>	\$20 visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>
<b><i>Self- Referred Network</i></b>	60% per visit after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>

<b><i>Alternatives to Physicians' Office Visit</i></b>		
<b><i>E-Visit Online Internet Consultation by a PCP</i></b>		
<b><i>Preferred Network</i></b>	100% per visit No Calendar Year <b>deductible</b> applies	No Coverage
<b><i>Referred Network</i></b>	\$20 visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies.	No Coverage
<b><i>Self Referred Network</i></b>	No Coverage	No Coverage

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Specialist Office Visits Preferred Network</b>	\$25 visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<b>Referred Network</b>	\$25 visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<b>Self-Referred Network</b>	60% per visit after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>

<b>Alternative to Specialist Office Visit</b>		
<b>E-visits Online Internet Consultation by a Specialist.</b>		
<b>Preferred Network</b>	100% per visit No Calendar Year <b>deductible</b> applies	No Coverage
<b>Referred Network</b>	\$25 visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b>	No Coverage
<b>Self-Referred Network</b>	Not Coverage	No Coverage

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Physician Office Visits-Surgery</i></b>		
<b><i>Physician Preferred Network</i></b>	100% per visit No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>
<b>Physician Referred Network</b>	\$20 per visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>
<b>Physician Self-Referred Network</b>	60% per visit after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<b><i>Specialist Preferred Network</i></b>	\$25 per visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>
<b><i>Specialist Referred Network</i></b>	\$25 per visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<b><i>Specialist Self-referred Network</i></b>	60% per visit after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>

<b><i>Walk-In Clinics Non-Emergency Visit</i></b>	\$25 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>
---	--	---

<b><i>Physician Services for Inpatient Facility and Hospital Visits</i></b>		
<b><i>Preferred Network</i></b>	95% per visit after <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<b><i>Referred Network</i></b>	80% per visit after <b>referred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<b><i>Self-Referred Network</i></b>	60% per visit after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<i>Administration of Anesthesia</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>Allergy Testing and Treatment Preferred Network</i>	100% per visit after applicable copay No Calendar Year deductible applies	60% per visit after Calendar Year deductible
<i>Referred Network</i>	100% per visit after applicable copay No Calendar Year deductible applies	60% per visit after Calendar Year deductible
<i>Self-Referred Network</i>	60% per visit after self-referred Calendar Year deductible	60% per visit after Calendar Year deductible
<i>Allergy Injections Preferred Network</i>	100% per visit after preferred Calendar Year deductible.	60% per visit after Calendar Year deductible.
<i>Referred Network</i>	100% per visit after preferred Calendar Year deductible	60% per visit after Calendar Year deductible
<i>Self-Referred Network</i>	60% per visit after self-referred Calendar Year deductible	60% per visit after Calendar Year deductible
<i>Immunizations (when not part of the physical exam)</i>	100% No Calendar Year deductible applies	No Coverage
<i>Prenatal Visits</i>	\$25 copay first visit only then the plan pays 100%	60% after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Emergency Medical Services</b>		
<b>Hospital Emergency Facility and Physician</b>	\$100 <b>copay</b> per visit then the plan pays 100% No Calendar Year <b>deductible</b> applies.	\$100 <b>deductible</b> per visit then the plan pays 100% No Calendar Year <b>deductible</b> applies.
See Important Note Below		
<p><b>Important Note:</b> Please note that as these providers are not <b>network providers</b> and do not have a contract with <b>Aetna</b>, the provider may not accept payment of your cost share (your <b>deductible</b> and <b>payment percentage</b>), 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 <b>physician</b> bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.</p>		
<b>Non-Emergency Care in a Hospital Emergency Room</b>	\$100 <b>copay</b> per visit then the plan pays 100% No Calendar Year <b>deductible</b> applies	\$100 <b>deductible</b> per visit then the plan pays 100% No Calendar Year <b>deductible</b> applies
<p><b>Important Notice:</b> A separate <b>hospital</b> emergency room <b>deductible</b> or <b>copay</b> applies for each visit to an emergency room for emergency care. If you are admitted to a <b>hospital</b> as an inpatient immediately following a visit to an emergency room, your <b>deductible</b> or <b>copay</b> is waived.</p> <p>Covered expenses that are applied to the emergency room <b>deductible</b> or <b>copay</b> cannot be applied to any other <b>deductible</b> or <b>copay</b> under your plan. Likewise, covered expenses that are applied to any of your plan's other <b>deductibles</b> or <b>copays</b> cannot be applied to the emergency room <b>deductible</b> or <b>copay</b>.</p>		
<b>Urgent Care Services</b>		
<b>Urgent Medical Care</b> <i>(at a non-hospital free standing facility)</i>	\$100 per visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies.	\$100 per visit <b>deductible</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies.
<b>Urgent Medical Care</b> <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.
<b>Non-Urgent Use of Urgent Care Provider</b> <i>(at an Emergency Room or a non-hospital free standing facility)</i>	\$100 per visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies.	\$100 per visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies.

**Important Notice:**

A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**.

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Outpatient Diagnostic and Preoperative Testing</i></b>		
<b><i>Complex Imaging Services</i></b>		
<b><i>Complex Imaging</i></b>	\$50 per visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies	\$50 per test <b>deductible</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies
<b><i>Diagnostic Laboratory Testing</i></b>		
<b><i>Performed in a Physician's office Preferred Network</i></b>	85% per procedure after <b>preferred</b> Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed in a Physician's office Referred Network</i></b>	85% per procedure after <b>preferred</b> Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed in a Physician's office Self-Referred Network</i></b>	85% per procedure after <b>preferred</b> Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed at a Hospital Outpatient Facility Preferred Network</i></b>	80% per procedure No Calendar Year <b>deductible</b> apply	60% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed at a Hospital Outpatient Facility Referred Network</i></b>	60% per procedure <b>after referred</b> Calendar Year <b>deductible</b>	60% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed at a Hospital Outpatient Facility Self-Referred Network</i></b>	60% per procedure after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed at any other Facility Preferred Network</i></b>	85% per procedure after <b>preferred</b> Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed at any other Facility Referred Network</i></b>	85% per procedure after <b>preferred</b> Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed at any other Facility Self-Referred Network</i></b>	85% per procedure after <b>preferred</b> Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>

<b>Diagnostic X-Rays (except Complex Imaging Services)</b>		
<b><i>Performed in a Physician's office Preferred Network</i></b>	85% per procedure after <b>preferred</b> Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed in a Physician's office Referred Network</i></b>	85% per procedure after <b>preferred</b> Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed in a Physician's office Self-Referred Network</i></b>	85% per procedure after <b>self-referred</b> Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed at a Hospital Outpatient Facility Preferred Network</i></b>	95% per procedure after <b>preferred</b> Calendar Year <b>deductible</b>	60% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed at a Hospital Outpatient Facility Referred Network</i></b>	80% per procedure after <b>referred</b> Calendar Year <b>deductible</b>	60% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed at a Hospital Outpatient Facility Self-Referred Network</i></b>	60% per procedure after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed at any other Facility Preferred Network</i></b>	85% per procedure after <b>preferred</b> Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed at any other Facility Referred Network</i></b>	85% per procedure after <b>preferred</b> Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
<b><i>Performed at any other Facility Self-Referred Network</i></b>	85% per procedure after <b>preferred</b> Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Outpatient Surgery</b>		
<b>Outpatient Surgery Facility Preferred Network</b>	95% per visit/surgical procedure after <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit/surgical procedure after Calendar Year <b>deductible</b>
<b>Referred Network</b>	80% per visit/surgical procedure after <b>referred</b> Calendar Year <b>deductible</b>	60% per visit/surgical procedure after Calendar Year <b>deductible</b>
<b>Self-Referred Network</b>	60% per visit/surgical procedure after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit/surgical procedure after Calendar Year <b>deductible</b>
<b>Outpatient Surgery (surgical) Preferred Network</b>	95% per visit/surgical procedure after <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit/surgical procedure after Calendar Year <b>deductible</b>
<b>Outpatient Surgery (surgical) Referred Network</b>	80% per visit/surgical procedure after <b>referred</b> Calendar Year <b>deductible</b>	60% per visit/surgical procedure after Calendar Year <b>deductible</b>
<b>Outpatient Surgery (surgical) Self-Referred Network</b>	60% per visit/surgical procedure after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit/surgical procedure after Calendar Year <b>deductible</b>
<b>Performed at an Ambulatory Surgery Center or Facility other than a Hospital Outpatient Facility</b>		
<b>Preferred Network</b>	85% per visit/surgical procedure after <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit/surgical procedure after Calendar Year <b>deductible</b>
<b>Referred Network</b>	85% per visit/surgical procedure after <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit/surgical procedure after Calendar Year <b>deductible</b>
<b>Self Referred Network</b>	60% per visit/surgical procedure after <b>self-referred</b> Calendar Year <b>deductible</b> .	60% per visit/surgical procedure after Calendar Year <b>deductible</b>
<p>*All charges related to the performance of one or more surgical procedures per date of service per facility including the induction and/or provision of anesthesia, use of operating room, recovery room services and all ancillary charges. Ancillary charges include, but are not limited to, surgical supplies, drugs administered, anesthetics and related supplies, nurse anesthetic services, implants, prosthetics, operating room assistants and other</p>		

personnel utilized in the provision of the all surgical procedures performed. Not included are charges for the professional services of the surgeon(s), anesthesiologist, or other physician

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Inpatient Facility Expenses</i></b>		
<b><i>Birth Center</i></b>	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.
<b><i>Hospital Facility Expenses</i></b>		
<b><i>Preferred Network</i></b> (excluding maternity) Room and Board	95% per admission after <b>preferred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Referred Network</i></b>	80% per admission after <b>referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Self-Referred Network</i></b>	60% per admission after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
Other than Room and Board <b>Preferred Network</b>	95% per admission after <b>preferred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
Other than Room and Board <b>Referred Network</b>	80% per admission after <b>referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
Other than Room and Board <b>Self-Referred Network</b>	60% per admission after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>

<b><i>Hospital Facility Expenses</i></b>		
Room and Board - Maternity		
<b><i>Preferred Network</i></b>	100% per admission after <b>preferred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Referred Network</i></b>	100% per admission after <b>referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Self-Referred Network</i></b>	60% per admission after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
Other than Room and Board <b>Preferred Network</b>	100% per admission after <b>preferred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
Other than Room and Board <b>Referred Network</b>	100% per admission after <b>referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
Other than Room and Board <b>Self-Referred Network</b>	60% per admission after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Skilled Nursing Inpatient Facility</i></b>		
<b><i>Preferred Network</i></b>	100% per admission after <b>preferred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Referred Network</i></b>	100% per admission after <b>preferred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Self-Referred Network</i></b>	60% per admission after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
Maximum Days per Calendar Year	100 days	100 days

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Specialty Benefits</i></b>		
<b><i>Home Health Care (Outpatient) Preferred Network</i></b>	100% per visit after the <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit after the Calendar Year <b>deductible</b>
<b><i>Referred Network</i></b>	100% per visit after the <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit after the Calendar Year <b>deductible</b>
<b><i>Self-Referred Network</i></b>	60% per visit after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit after the Calendar Year <b>deductible</b>

<b>Hospice Benefits</b>		
<b>Hospice Care - Facility Expenses</b> (Room & Board) <b>Preferred Network</b>	100% per admission after <b>preferred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b>Referred Network</b>	100% per admission after <b>preferred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b>Self-Referred Network</b>	60% per admission after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b>Hospice Care - Other Expenses during a stay( Preferred Network)</b>	100% per admission after <b>preferred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b>Referred Network</b>	100% per admission after <b>preferred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b>Self-Referred Network</b>	60% per admission after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b>Hospice Outpatient Visits Preferred Network</b>	100% per visit after <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<b>Referred Network</b>	100% per visit after <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<b>Self-Referred Network</b>	60% per visit after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Treatment</b>		
<b>Basic Infertility Expenses</b> 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.
<b>Comprehensive Infertility Expenses Preferred Network</b>	80% after <b>preferred</b> Calendar Year <b>deductible</b>	No Coverage
<b>Referred Network</b>	80% after <b>preferred</b> Calendar Year <b>deductible</b>	No Coverage
<b>Self-Referred Network</b>	No Coverage	No Coverage

Artificial Insemination Maximum Benefit*	6 courses of treatment per lifetime*	No Coverage
Ovulation Induction Maximum Benefit*	6 courses of treatment per lifetime*	No Coverage
Maximum per lifetime combined with (ART)*	\$20,000*	Not Applicable
*Does not apply toward the plan out-of-pocket limit		

<b><i>Advanced Reproductive Technology (ART) Expenses</i></b>	80% after <b>preferred deductible</b>	Calendar Year	No Coverage
<b><i>Preferred Network</i></b>	80% after <b>preferred deductible</b>	Calendar Year	No Coverage
<b><i>Referred Network</i></b>			No Coverage
<b><i>Self-Referred</i></b>	No Coverage		No Coverage

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Mental Disorders</i>		
<b>MENTAL DISORDERS</b>		
<i>Hospital Facility Expenses Preferred Network</i> Room and Board	95% per admission No Calendar Year deductible applies	60% per admission after Calendar Year deductible
<i>Hospital Facility Expenses Referred Network</i> Room and Board	95% per admission No Calendar Year deductible applies	60% per admission after Calendar Year deductible
<i>Hospital Facility Expenses Self-Referred Network</i> Room and Board	60% per admission after self-referred Calendar Year deductible	60% per admission after Calendar Year deductible
<b>Preferred Network</b> Other than Room and Board	95% per admission No Calendar Year deductible applies	60% per admission after Calendar Year deductible
<i>Referred Network</i> Other than Room and Board	95% per admission No Calendar Year deductible applies	60% per admission after Calendar Year deductible
<i>Self-Referred Network</i> Other than Room and Board	60% per admission after self-referred Calendar Year deductible	60% per admission after Calendar Year deductible
Physician Services <b>Preferred Network</b>	95% after preferred Calendar Year deductible	60% per admission after Calendar Year deductible
Physician Services <b>Referred Network</b>	80% after referred Calendar Year deductible	60% per admission after Calendar Year deductible
Physician Services <b>Self-Referred Network</b>	60% after self-referred Calendar Year deductible	60% per admission after Calendar Year deductible

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Inpatient Residential Treatment Facility Expenses Preferred Network</i></b>	95% per admission No Calendar Year <b>deductible</b> applies	60% per admission after Calendar Year <b>deductible</b>
<b><i>Referred Network</i></b>	95% per admission No Calendar Year <b>deductible</b> applies	60% per admission after Calendar Year <b>deductible</b>
<b><i>Self Referred Network</i></b>	60% per admission after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Inpatient Residential Treatment Facility Expenses Physician Services Preferred Network</i></b>	95% after <b>preferred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Referred Network</i></b>	80% after <b>referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Self-Referred Network</i></b>	60% after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>

Maximum Days per Calendar Year (Combined with Inpatient Residential Treatment Facility Maximum for Substance Abuse)	Unlimited	Unlimited
---	-----------	-----------

### ***Outpatient Treatment Of Mental Disorders***

<b><i>Outpatient Services Preferred Network</i></b>	\$25 per visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies	60% per visit after the Calendar Year <b>deductible</b>
<b><i>Referred Network</i></b>	\$25 per visit <b>copay</b> then the plan pays 100%	60% per visit after the Calendar Year <b>deductible</b>
<b><i>Self-Referred Network</i></b>	60% per visit after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit after the Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Inpatient Treatment of Substance Abuse</i></b>		
<b><i>Hospital Facility Expenses Preferred Network</i></b>		
Room and Board	95% per admission No Calendar Year <b>deductible</b> applies	60% per admission after Calendar Year <b>deductible</b>
<b><i>Hospital Facility Expenses Referred Network</i></b>		
Room and Board	95% per admission No Calendar Year <b>deductible</b> applies	60% per admission after Calendar Year <b>deductible</b>
<b><i>Hospital Facility Expenses Self-Referred Network</i></b>		
Room and Board	60% per admission after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b>Preferred Network</b>		
Other than Room and Board	95% per admission No Calendar Year <b>deductible</b> applies	60% per admission after Calendar Year <b>deductible</b>
<b>Referred Network</b>		
Other than Room and Board	95% per admission No Calendar Year <b>deductible</b> applies	60% per admission after Calendar Year <b>deductible</b>
<b>Self-Referred Network</b>		
Other than Room and Board	60% per admission after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b>Physician Services Preferred Network</b>		
	95% after <b>preferred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b>Physician Services Referred Network</b>		
	80% after <b>referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b>Physician Services Self-Referred Network</b>		
	60% after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Inpatient Residential Treatment Facility Expenses</i></b>	95% per admission No Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Referred Network</i></b>	95% per admission No Calendar Year <b>deductible</b> applies	60% per admission after Calendar Year <b>deductible</b>
<b><i>Self Referred Network</i></b>	60% per admission after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Inpatient Residential Treatment Facility Expenses Physician Services Preferred Network</i></b>	95% after <b>preferred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Referred Network</i></b>	80% after <b>referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Self-Referred Network</i></b>	60% after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>

Maximum Days per Calendar Year (Combined with Inpatient Residential Treatment Facility Maximum for Mental Disorders)	Unlimited	Unlimited
--	-----------	-----------

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Outpatient Treatment of Substance Abuse</i></b>		
<b><i>Outpatient Treatment Preferred Network (Office Visit)</i></b>	\$25 per visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>
<b><i>Referred Network (Office Visit)</i></b>	\$25 per visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>
<b><i>Self-Referred Network (Office Visit)</i></b>	60% after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<b><i>Outpatient Treatment Preferred Network (Other than Office Visit)</i></b>	95% per visit No Calendar Year <b>deductible</b> or <b>copay</b> applies	60% per visit after Calendar Year <b>deductible</b>
<b><i>Referred Network (Other than Office Visit)</i></b>	95% per visit No Calendar Year <b>deductible</b> or <b>copay</b> applies	60% per visit after Calendar Year <b>deductible</b>
<b><i>Self-Referred Network (Other than Office Visit)</i></b>	60% per visit after <b>self-referred</b> Calendar Year <b>deductible</b> no <b>copay</b> applies	60% per visit after Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Obesity Treatment Non Surgical</b>		
<i>Outpatient Obesity Treatment (non surgical) Central Maine Medical Center, Eastern Maine Medical Center and Maine Medical Center</i>	100% per visit after <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit after the Calendar Year <b>deductible</b>
<i>Preferred Network</i>	95% per visit after <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit after the Calendar Year <b>deductible</b>
<i>Referred Network</i>	95% per visit after <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit after the Calendar Year <b>deductible</b>
<i>Self-Referred Network</i>	60% after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit after the Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Obesity Treatment Surgical</b>		
<i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services) ) Central Maine Medical Center, Eastern Maine Medical Center and Maine Medical Center</i>	100% per admission after <b>preferred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<i>Preferred Network</i>	95% per admission after <b>preferred</b> Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<i>Referred Network</i>	95% per visit after <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit after the Calendar Year <b>deductible</b>
<i>Self-Referred Network</i>	60% after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit after the Calendar Year <b>deductible</b>

<b><i>Outpatient Morbid Obesity Surgery</i></b> <i>(Central Maine Medical Center, Eastern Maine Medical Center and Maine Medical Center)</i>	100% per service after <b>preferred</b> Calendar Year <b>deductible</b>	60% per service after Calendar Year <b>deductible</b>
<b><i>Preferred Network</i></b>	95% per service after <b>preferred</b> Calendar Year <b>deductible</b>	60% per service after Calendar Year <b>deductible</b>
<b><i>Referred Network</i></b>	95% per service after <b>preferred</b> Calendar Year <b>deductible</b>	60% per services after Calendar Year <b>deductible</b>
<b><i>Self- Referred Network</i></b>	60% per services after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per service after Calendar Year <b>deductible</b>

Maximum Travel and Lodging Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	\$10,000 per lifetime	\$10,000 per lifetime
This maximum includes benefits provided or administered by Aetna or any affiliated company of Aetna		

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
<b><i>Transplant Services Facility and Non-Facility Expenses</i></b>			
<b><i>Transplant Facility Expenses</i></b>	100% per admission after Calendar Year <b>deductible</b>	100% per admission after Calendar Year <b>deductible</b>	100% per admission after Calendar Year <b>deductible</b>
<b><i>Transplant Physician Services</i></b> (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 (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
<b><i>Transplant Services Facility and Non-Facility Expenses</i></b>			
<b><i>Transplant Facility Expenses</i></b>	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.
<b><i>Transplant Physician Services</i></b> (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
<i>Other Covered Health Expenses</i>		
<i>Acupuncture</i>		
<b>Preferred Network</b>	\$25 per visit copay then the plan pays 100% No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>
<b>Referred Network</b>	\$25 per visit copay then the plan pays 100% No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>
<b>Self-Referred Network</b>	50% per visit after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<i>Ground, Air or Water Ambulance</i>	100% after <b>preferred</b> Calendar Year <b>deductible</b>	100% after preferred Calendar Year <b>deductible</b>
<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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Durable Medical and Surgical Equipment (Preferred Network)</i>	100% per item after <b>preferred</b> Calendar Year <b>deductible</b>	60% per item after the Calendar Year <b>deductible</b>
<i>Referred Network</i>	100% per item after <b>preferred</b> Calendar Year <b>deductible</b>	60% per item after the Calendar Year <b>deductible</b>
<i>Self-Referred Network</i>	60% per item after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per item after the Calendar Year <b>deductible</b>
<i>Jaw Joint Disorder Treatment (Preferred Network)</i>	100% per visit after <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<i>Referred Network</i>	100% per visit after <b>preferred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<i>Self-Referred Network</i>	60% per visit after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<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 (Preferred Network)</i>	100% per item after <b>preferred</b> Calendar Year <b>deductible</b>	60% per item after Calendar Year <b>deductible</b>
<i>Referred Network</i>	100% per item after <b>preferred</b> Calendar Year <b>deductible</b>	60% per item after Calendar Year <b>deductible</b>
<i>Self-Referred Network</i>	60% per item after <b>self-referred</b> Calendar Year <b>deductible</b>	60% per item after Calendar Year <b>deductible</b>
<i>Limb replacement</i>	80% per item No Calendar Year <b>deductible</b> applies	80% per item after Calendar Year <b>deductible</b>

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
<i>Short Term Outpatient Rehabilitation Therapies</i>		

<i>Outpatient Physical and Occupational Therapy only</i>		
<i>Preferred Network</i>	\$25 visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>
<i>Referred Network</i>	\$25 visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>
<i>Self-Referred</i>	60% per visit after <b>self-referred</b> Calendar Year <b>deductible</b> no <b>copay</b> applies	60% per visit after Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Short Term Outpatient Rehabilitation Therapies</b>		
<i>Speech Therapy only (Preferred Network)</i>	\$25 per visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>
<i>Referred Network</i>	\$25 per visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>
<i>Self-Referred</i>	60% per visit after <b>self-referred</b> Calendar Year <b>deductible</b> no <b>copay</b> applies	60% per visit after Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Spinal Manipulation</b>		
<i>Preferred Network</i>	\$20 or \$25 per visit <b>copay</b> then plan pays 100% No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>
<i>Referred Network</i>	\$20 or \$25 visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>
<i>Self-Referred</i>	60% per visit after <b>self-referred</b> Calendar Year <b>deductible</b> no <b>copay</b> applies	60% per visit after Calendar Year <b>deductible</b>

## Pharmacy Benefit

### Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<b>Preferred Generic Prescription Drugs</b>		
For each 30 day supply (retail)	\$10	\$10
For more than a 30 day supply but less than a 91 day supply (mail order)	\$15	Not Applicable
<b>Preferred Brand-Name Prescription Drugs</b>		
For each 30 day supply (retail)	\$30	\$30
For more than a 30 day supply but less than a 91 day supply (mail order)	\$45	Not Applicable

<b>Non-Preferred Generic Prescription Drugs</b>		
For each 30 day supply (retail)	\$10	\$10
For more than a 30 day supply but less than a 91 day supply (mail order)	\$15	Not Applicable

<b>Non-Preferred Brand-Name Prescription Drugs</b>		
For each 30 day supply (retail)	\$45	\$45
For more than a 30 day supply but less than a 91 day supply (mail order)	\$70	Not Applicable

<b>Infertility/ Erectile Dysfunction Prescription Drugs</b>		
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.

#### Coinsurance

	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Prescription Drug Plan Coinsurance</b>	100% of the <b>negotiated charge</b>	100% of the <b>recognized charge</b>

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** 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 **referred network provider** deductibles will be applied to satisfy the **preferred network provider deductibles**. Covered expenses applied to the **preferred network provider deductibles** will be applied to satisfy the referred network provider deductibles.

**Covered expenses** applied to the **out-of-network provider** or **self-referred network provider deductibles** will not be applied to satisfy the **preferred and referred network provider deductibles**. **Covered expenses** applied to the **preferred and referred network provider deductibles** will not be applied to satisfy the **out-of-network provider** or **self-referred network provider deductibles**.

All covered expenses accumulate toward the preferred, referred, and self-referred 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.

## 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**.

## 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.

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**.

#### 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** and **other health care 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.

**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 Payment Limit

Certain covered expenses do not apply toward your plan payment limit. These include:

- Expenses applied toward a **deductible**;
- Charges over the **recognized charge**;
- **Covered expenses** incurred from a **network provider** that are subject to a **maximum allowable amount** to the extent that the **negotiated charge** is more than the **maximum allowable amount**. In that event, the difference between the **negotiated charge** and the **maximum allowable amount** does not count toward any **payment limit** under the plan;
- **Covered expenses** incurred from an **out-of-network provider** that are subject to a **maximum allowable amount** to the extent that the billed charge is more than the **maximum allowable amount**. In that event, the difference between the billed charge and the **maximum allowable amount** does not count toward any **payment limit** under the plan;
- Expenses applied toward a **copayment**;
- Expenses incurred for outpatient **prescription drugs**;

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

### **Precertification Benefit Reduction**

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

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

- A \$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.