# Schedule of Benefits

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| **Employer:** | **Rice University** |
| **MSA:** | 878783 |
| **Issue Date:** | October 20, 2016 |
| **Effective Date:** | July 1, 2016 |
| **Schedule:** | 6A |
| **Booklet Base:** | 6 |

For: Choice POS II - High Deductible Health Plan

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

**Aetna Choice POS II Medical Plan**

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Plan Year Deductible*** | | |
| **Individual Deductible*** | $2,600 | $7,800 |
| **Family Deductible*** | $7,800 | $23,400 |

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

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

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

**Individual Maximum Out of Pocket Limit:**

- For **network** expenses: $5,000.
- For **out-of-network** expenses: $9,000.

**Family Maximum Out of Pocket Limit:**

- For **network** expenses: $12,500.
- For **out-of-network** expenses: $27,000.

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| ***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 Plan 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***<br>***Office Visits*** | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% per visit after Plan Year **deductible** |
| *Covered Persons through age 21*:<br>Maximum Age & Visit Limits | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.<br><br>*For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.* | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.<br><br>*For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card* |
| *Covered Persons ages 22 but less than 65*:<br>Maximum Visits per 12 consecutive months | 1 visit | 1 visit |
| *Covered Persons age 65 and over*:<br>Maximum Visits per 12 consecutive months | 1 visit | 1 visit |

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|---|---|---|
| ***Preventive Care Immunizations***<br>*Performed in a facility or* ***physician's*** *office* | 100% per visit<br><br>No **copay** or **deductible** applies.<br><br>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.<br><br>*For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.* | 60% per visit after Plan Year **deductible**<br><br>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.<br><br>*For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.* |
| ***Screening & Counseling Services***<br><br>***Office Visits***<br>***Obesity and/or Healthy Diet***<br><br>***Misuse of Alcohol and/or Drugs & Use of Tobacco Products***<br><br>***Sexually Transmitted Infections***<br><br>***Genetic Risk for Breast and Ovarian Cancer*** | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% per visits after Plan Year **deductible** |
| *Obesity and/or Healthy Diet*<br>Maximum Visits per 12 consecutive months<br>*(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)* ***** |
| ***Note:** **In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.*** | | |
| *Misuse of Alcohol and/or Drugs*<br>Maximum Visits per 12 consecutive months | 5 visits * | 5 visits * |
| ***Note:** **In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.*** | | |

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| *Use of Tobacco Products*<br>Maximum Visits per 12 consecutive months | 8 visits* | 8 visits* |
| ***Note:** **In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.*** | | |
| *Sexually Transmitted Infections Benefit Maximums*<br><br>Maximum Visits per Plan Year | 2 visits* | 2 visits* |
| ***Note:** **In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.*** | | |
| ***Well Woman Preventive Visits***<br>***Office Visits***<br><br>Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations | 100% per visit<br><br>No Plan Year **deductible** applies. | 60% per visit after Plan Year **deductible** |
| ***Well Woman Preventive Visits***<br>Maximum Visits per Plan Year | 1 visit | 1 visit |
| ***Hearing Exam*** | 100% per exam<br><br>No Plan Year **deductible** applies. | 60% per exam after Plan Year **deductible** |
| Maximum exams per 12 month period | 1 exam | 1 exam |
| ***Routine Cancer Screening***<br>***Outpatient*** | 100% per visit<br><br>No Plan Year **deductible** applies. | 60% per visit after Plan Year **deductible** |

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| Maximums | Subject to any age; family history and frequency guidelines as set forth in the most current:<br>• evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and<br>• the comprehensive guidelines supported by the Health Resources and Services Administration.<br><br>*For details, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com, or calling the number on the back of your ID card.* | Subject to any age; family history and frequency guidelines as set forth in the most current:<br>• evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and<br>• the comprehensive guidelines supported by the Health Resources and Services Administration.<br><br>*For details, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com, or calling the number on the back of your ID card.* |
| *Lung Cancer Screening Maximum* | One screening every 12 months* | One screening every 12 months* |
| ***Important Note: *Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.*** | | |
| ***Prenatal Care***<br>***Office Visits*** | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% per visit after Plan Year **deductible** |
| **Important Note**: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits. | | |
| ***Comprehensive Lactation Support and Counseling Services*** | | |
| **Lactation Counseling Services**<br>*Facility or Office Visits* | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% per visit after Plan Year **deductible** |
| Lactation Counseling Services Maximum Visits either in a group or individual setting | 6* visits per 12 months | Not Applicable |
| ***Important Note**: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*. | | |
| **Breast Pumps & Supplies** | 100% per item<br><br>No **copay** or **deductible** applies | 60% per item after Plan Year **deductible** |
| **Important Note**: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies. | | |

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| ***Family Planning Services*** | | |
| Female Contraceptive Counseling Services -Office Visits | 100% per visit.<br><br>No **copay** or **deductible** applies. | 60% per visit after Plan Year **deductible** |
| Contraceptive Counseling Services - Maximum Visits either in a group or individual setting | 2* visits per 12 months | Not Applicable |
| *Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*. | | |
| ***Family Planning Services - Female Contraceptives*** | | |
| Female Contraceptive Generic **Prescription Drugs** and Devices provided, administered, or removed, by a **Physician** during an Office Visits. | 100% per item.<br><br>No **copay** or **deductible** applies. | 60% per item after Plan Year **deductible** |
| ***Family Planning - Other*** | | |
| Voluntary Termination of Pregnancy Outpatient | 80% per visit after Plan Year **deductible** | 60% per visit after Plan Year **deductible** |
| Voluntary Sterilization for Males Outpatient | 80% per visit after Plan Year **deductible** | 60% per visit after Plan Year **deductible** |
| ***Family Planning - Female Voluntary Sterilization*** | | |
| ***Inpatient*** | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% per visit after Plan Year **deductible** |
| ***Outpatient*** | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% per visit after Plan Year **deductible** |
| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** |
| ***Vision Care*** | | |
| ***Eye Examinations*** including refraction | 100% per exam<br><br>No Plan Year **deductible** applies. | Not Covered |
| Maximum Benefit per 12 consecutive month period | 1 exam | Not covered |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Physician Services*** | | |
| ***Office Visits to Primary Care Physician***<br>Office visits (non-surgical) to non-specialist | 80% per visit after Plan Year **deductible** | 60% per visit after Plan Year **deductible** |
| ***Specialist Office Visits*** | 80% per visit after Plan Year **deductible** | 60% per visit after Plan Year **deductible** |
| ***Physician Office Visits-Surgery*** | 80% per visit after Plan Year **deductible** | 60% per visit after Plan Year **deductible** |
| ***Walk-In Clinic Visit (Non-Emergency)*** | | |
| ***Preventive Care Services**** | | |
| Immunizations | 100% per visit<br><br>No **copay** or **deductible** applies.<br><br>For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card. | 60% per visit after Plan Year **deductible** |
| Individual Screening and Counseling Services for Tobacco Use | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% per visits after Plan Year **deductible** |
| Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use | Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services | Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services |
| Individual Screening and Counseling Services for Obesity | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% per visits after Plan Year **deductible** |
| Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity | Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services | Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services |
| ***Important Note**:<br>Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**. | | |
| ***All Other Services*** | 80% per visit after Plan Year **deductible** | 60% per visit after Plan Year **deductible** |

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| ***Physician Services for Inpatient Facility and Hospital Visits*** | 80% per visit after Plan Year **deductible** | 60% per visit after Plan Year **deductible** |
| ***Administration of Anesthesia*** | 80% per procedure after Plan Year **deductible** | 60% per procedure after Plan Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Emergency Medical Services*** | | |
| ***Hospital Emergency Facility and Physician*** | 80% per visit after the Plan Year **deductible** | Paid the same as the Network level of benefits.<br><br>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*** | Not covered | Not covered |
| ***Urgent Care Services*** | | |
| ***Urgent Medical Care*** *(at a non-hospital free standing facility)* | 80% per visit after Plan Year **deductible** | 60% per visit after Plan Year **deductible** |
| ***Urgent Medical Care*** *(from other than a non-hospital free standing facility)* | Refer to *Emergency Medical Services* and *Physician Services* above. | Refer to *Emergency Medical Services* and *Physician Services* above. |
| ***Non-Urgent Use of Urgent Care Provider*** *(at an Emergency Room or a non-hospital free standing facility)* | Not covered | Not covered |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Outpatient Diagnostic and Preoperative Testing*** | | |
| ***Complex Imaging Services*** | | |
| ***Complex Imaging*** | 80% per test after Plan Year **deductible** | 60% per test after Plan Year **deductible** |

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| ***Diagnostic Laboratory Testing*** | | |
| ***Diagnostic Laboratory Testing*** | 80% per procedure after Plan Year **deductible** | 60% per procedure after Plan Year **deductible** |
| ***Diagnostic X-Rays (except Complex Imaging Services)*** | | |
| ***Diagnostic X-Rays*** | 80% per procedure after Plan Year **deductible** | 60% per procedure after Plan Year **deductible** |
| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** |
| ***Outpatient Surgery*** | | |
| ***Outpatient Surgery*** | 80% per visit/surgical procedure after Plan Year **deductible** | 60% per visit/surgical procedure after Plan Year **deductible** |
| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** |
| ***Inpatient Facility Expenses*** | | |
| ***Birthing Center*** | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Hospital Facility Expenses***<br>Room and Board (including maternity)<br>Other than Room and Board | 80% per admission after Plan Year **deductible**<br><br>80% per admission after Plan Year **deductible** | 60% per admission after Plan Year **deductible**<br><br>60% per admission after Plan Year **deductible** |
| ***Skilled Nursing Inpatient Facility*** | 80% per admission after Plan Year **deductible** | 60% per admission after Plan Year **deductible** |
| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** |
| ***Specialty Benefits*** | | |
| ***Home Health Care (Outpatient)*** | 80% per visit after the Plan Year **deductible** | 60% per visit after the Plan Year **deductible** |
| ***Skilled Nursing Care (Outpatient)*** | 80% per visit after the Plan Year **deductible** | 60% per visit after the Plan Year **deductible** |
| ***Private Duty Nursing (Outpatient)*** | 80% per visit after the Plan Year **deductible** | 60% per visit after the Plan Year **deductible** |
| Maximum Visit Limit per *Plan Year* | 70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift. | 70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift. |

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| ***Hospice Benefits*** | | |
| ***Hospice Care - Facility Expenses*** (Room & Board) | 80% per admission after Plan Year **deductible** | 60% per admission after Plan Year **deductible** |
| ***Hospice Care - Other Expenses during a stay*** | 80% per admission after Plan Year **deductible** | 60% per admission after Plan Year **deductible** |
| Maximum Benefit per lifetime | Unlimited days | Unlimited days |
| ***Hospice Outpatient Visits*** | 80% per visit after Plan Year **deductible** | 60% per visit after Plan Year **deductible** |

| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** |
|---|---|---|
| ***Infertility Treatment*** | | |
| ***Basic Infertility Expenses*** Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only. | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |

| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** |
|---|---|---|
| ***Inpatient Treatment of Mental Disorders*** | | |
| ***MENTAL DISORDERS*** | | |
| ***Hospital Facility Expenses*** | | |
| Room and Board | 80% per admission after Plan Year **deductible** | 60% per admission after Plan Year **deductible** |
| Other than Room and Board | 80% per admission after Plan Year **deductible** | 60% per admission after Plan Year **deductible** |
| Physician Services | 80% per admission after Plan Year **deductible** | 60% per admission after Plan Year **deductible** |
| ***Inpatient Residential Treatment Facility Expenses*** | 80% per admission after Plan Year **deductible** | 60% per admission after Plan Year **deductible** |
| ***Inpatient Residential Treatment Facility Expenses Physician Services*** | 80% after Plan Year **deductible** | 60% after Plan Year **deductible** |

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| ***Outpatient Treatment Of Mental Disorders*** | | |
| ***Outpatient Services*** | 80% per visit after the Plan Year **deductible** | 60% per visit after the Plan Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Inpatient Treatment of Substance Abuse*** | | |
| ***Hospital Facility Expenses*** | | |
| Room and Board | 80% per admission after Plan Year **deductible** | 60% per admission after Plan Year **deductible** |
| Other than Room and Board | 80% per admission after Plan Year **deductible** | 60% per admission after Plan Year **deductible** |
| Physician Services | 80% per admission after Plan Year **deductible** | 60% per admission after Plan Year **deductible** |
| ***Inpatient Residential Treatment Facility Expenses*** | 80% per admission after Plan Year **deductible** | 60% per admission after Plan Year **deductible** |
| ***Inpatient Residential Treatment Facility Expenses Physician Services*** | 80% per visit after Plan Year **deductible** | 60% per visit after Plan Year **deductible** |

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

| PLAN FEATURES | NETWORK (IOE Facility) | NETWORK (Non-IOE Facility) | OUT-OF-NETWORK |
|---|---|---|---|
| ***Transplant Services Facility and Non-Facility Expenses*** | | | |
| ***Transplant Facility Expenses*** | 80% per admission after Plan Year **deductible** | 60% per admission after Plan Year **deductible** | 60% per admission after Plan Year **deductible** |
| ***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 Plan Year **deductible** | 80% after Plan Year **deductible** |
| ***Durable Medical and Surgical Equipment*** | 80% per item after the Plan Year **deductible** | 60% per item after the Plan Year **deductible** |
| ***Clinical Trial Therapies*** (Experimental or Investigational Treatment) | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Routine Patient Costs*** | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)*** | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Prosthetic Devices*** | 80% per item after Plan Year **deductible** | 60% per item after Plan Year **deductible** |
| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** |
| ***Outpatient Therapies*** | | |
| ***Chemotherapy*** | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Infusion Therapy*** | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Radiation Therapy*** | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Short Term Outpatient Rehabilitation Therapies*** | | |
| ***Outpatient Physical and Occupational Therapy only*** | 80% per visit after Plan Year **deductible** | 60% per visit after Plan Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Short Term Outpatient Rehabilitation Therapies*** | | |
| ***Speech Therapy only*** | 80% per visit after Plan Year **deductible** | 60% per visit after Plan Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Spinal Manipulation*** | | |
| | 80% per visit after Plan Year **deductible** | 60% per visit after Plan Year **deductible** |
| Spinal Manipulation Maximum visits per Plan Year | 20 visits | 20 visits |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Autism Spectrum Disorder*** | | |
| ***Autism - Applied Behavior Analysis*** | 80% per visit after Plan Year **deductible** | 60% per visit after Plan Year **deductible** |

## 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*.

**Covered expenses** that are subject to the **deductibles** include covered expenses provided under the Medical or **Prescription drug** Plans, as applicable. Integration is with the Rx third party vendor.

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

**Network Provider** Plan Year **Deductible**

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

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

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

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

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

**Out-of-Network Provider** Plan Year **Deductible**

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

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

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

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

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

## Payment Provisions

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

**Maximum Out-of-Pocket Limit**
The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Plan 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 Plan 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 Plan 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 Plan 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 Plan 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 Plan 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 Plan 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 Plan 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 Plan 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 Plan 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 Plan 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**.

**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. Integration is with the Rx third party vendor.

**Expenses That Do Not Apply to Your Out-of-Pocket Limit**
Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

### Precertification Benefit Reduction

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

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

- A $400 benefit reduction will be applied separately to each type of expense.

# General

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